Transition of care among young offenders with ongoing mental health problems in England: young offenders in transition

By

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List of terms and Abbreviations

ADHD -Attention Deficit Hyperactivity Disorder
AMHS- Adult Mental Health Services
ASD- Autism Spectrum Disorder
ASPD- Antisocial Personality Disorder
BDD- Body Dysmorphic Disorder
BME- Black and Minority Ethnic
BPD- Borderline Personality Disorder
CAMHS- Child and Adolescent Mental Health Services
CI- confidence interval
CPA- Care Programme Approach
CD- Conduct Disorder
DH- Department of Health
DSM- Diagnostic and Statistical Manual of Mental Disorders
DISC- Diagnostic Interview for Children
ECT- Electro-Convulsive Therapy
EIS- Early Intervention Services
FCAMHS- Forensic Child and Adolescent Mental Health Services
GAD-Generalised Anxiety Disorder
GLM- Good Lives Model
GP- General Practitioner
HSU- High Secure Unit
HoNOSCA- Health of the Nation Outcome Scales for Children and Adolescents
ICD- International Classification of Diseases
K-SADS-PL- Kiddie Schedule for Affective Disorders and Schizophrenia
LAC-Looked After Children
LASCH- Local Authority Secure Children's Home
LSU- Low Secure Unit
MHA-Mental Health Act
MINI-Kid- Mini-International Neuropsychiatric Interview for Children and Adolescents
MD- Mental Disorder
MDT- Multidisciplinary team
MOOSE- meta-analysis of observational studies in epidemiology
MSU- Medium Secure Unit
NCG- National Commissioning Group
NHS- National Health Service
NICE- National Institute for Health and Care Excellence
NPD- Narcissistic Personality Disorder
OCD- Obsessive Compulsive Disorder
ODD- Oppositional Defiant Disorder
PADDI- Practical Adolescent Dual Diagnostic Interview
PD- Personality Disorder
PICU- Psychiatric Intensive Care Unit
PRISMA- Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD- Post-Traumatic Stress Disorder

RC- Responsible Clinician
RNR- Risk Need Responsivity
SAD- Separation Anxiety Disorder
SAVRY- Structured Assessment of Violent Risk in Youth
SCID- Structured Clinical Interview for DSM Disorders
SCH- Secure Children's Home
SCT- Supervised Community Treatment
SFMHSYP- Secure Forensic Mental Health service for Young People
STPD- Schizotypal Personality Disorder
T2A- Transition to Adulthood Alliance
STC- Secure Training Centre
YJB- Youth Justice Board
YOI-Young offending institution
YOT- Youth offending team
WAIS- Wechsler Adult Intelligence Scale
WEMSS- Women's Enhanced Medium Secure Service
WISC- Wechsler Intelligence Scale for Children

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“This PhD is dedicated to every child and young person in secure care hoping for a better present and future and a more contained and tolerant system.”

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Conferences

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Abstract

Background: Previous research has shown that transitions from child and adolescent mental health services to adult services are highly problematic for young people in the UK. The needs of young people during transition periods increase and care provision resources are limited.

Objectives: This research study aimed to examine the transition processes, policies and outcomes across all six nationally commissioned medium secure adolescent units in England.

Methods: This research study included four interlinked phases within a sequential exploratory mixed methods design that examined transition of care from forensic child and adolescent mental health services (FCAMHS) among young offenders with mental health problems. The first phase looked at the prevalence of mental disorders among young offenders with the use of a meta-analysis. A mapping exercise identified young people approaching 18 years within a six-month period. Thirty-two retrospective cases notes were reviewed looking at discharged patients the preceding year. Fifty-two face-to-face semi-structured interviews were carried out to explore healthcare providers', service users' and their families' transition experiences.

Results: The mapping exercise and case note review findings highlight the complexity of needs in this group. Subthemes elicited from the interviews with healthcare professionals included transitional delays and young people's lack of readiness to move onto adult services. Majority of the young people reported that they did not know the transition date whilst families described transitions as anxiety-provoking events.

Conclusions: This research study added an original contribution to the literature based on empirical findings that inform transition policy and clinical practice. This is the first prospective study that followed up young people across England to identify transition outcomes nationally. Policy makers need to aim for flexible age criteria to facilitate service transformation that is person-centred avoiding the traditional one-size-fits-all models of care.

'The current system is weakest where it needs to be strongest.'

(McGorry, 2013)

1 Introduction

This chapter presents the background and rationale of this thesis, which examined and explored the transitions of young people as they moved from forensic child and adolescent mental health services to adult and community settings. I describe the major service challenges embedded in the transition process as identified by the relevant literature. This research study aimed to bridge the current gap in the transition literature and to understand young people's needs and experiences during transition. Last, I outline the structure of this thesis by providing brief chapter summaries.

1.1 Background

Young offenders comprise a large proportion of the prison population and are at high risk of experiencing mental health disorders (Prison Reform Trust, 2012). As of 2014, 5,939 young offenders aged between 18 and 20 years were in custody, whilst youth under 21 made up 14% of the overall prison population in England and Wales (Prison Reform Trust, 2014). The Bradley Commission reported that 1,323 children aged between 10 and 18 years were detained, excluding those in secure hospitals (Snodgrass and Preston, 2015). Up to 81 per cent of young people within criminal justice agencies are known to present with mental health problems (Hagell, 2002), while a UK study identified 95 per cent of young offenders aged 16 to 20 years as having a mental health disorder (Lader *et al.,* 2003).

Young offenders with mental health problems undergo several transitions between and within the health, social care and criminal justice systems that can negatively affect their psychological health (Campbell *et al.,* 2014). The transition from child and adolescent to adult mental health services (AMHS) has been described as poorly planned, poorly executed and poorly experienced (Singh *et al.,* 2010). A poor transition may adversely affect

young people's health, well-being and successful integration into the community (Champion and Clare, 2006; Vyas *et al.,* 2015). Young offenders often present with complex backgrounds including parental criminality, loss of a parent, dysfunctional home environments, committed offences and mental health problems. Whilst these multiple transitions concur, specialist services should aim for joint transitions tackling risk factors (Brodie *et al.,* 2011).

1.2 Research gap

There is limited evidence about transition processes within forensic psychiatric services. Even less is known about long-term outcomes of those transitioned from forensic mental health adolescent hospitals to the community (Harrington *et al.,* 2005). A UK study including female adolescent patients from a medium secure hospital showed that nearly half of them were discharged to the community (Hill e*t al.,* 2014). This study did not look distinctly at transitions rather on discharge destinations within a four-year timeframe. Returning to the community might be especially difficult if young people lack supportive networks. Moving to an independent living brings additional challenges, such as risks of substance misuse and lack of appropriate housing and employment (DH, 2009). It is also known that the risk of reoffending increases when community mental health services do not engage young people in follow-up treatment (Hagell, 2002).

1.3 Current service problems

1.3.1 Transitional age boundaries

Transitional age boundaries are problematic in the UK as it is unclear at what age adult services start being accountable for young people (Singh *et al.,* 2010). Child mental health services provide care for young people until they reach the age of 18. Age is the only criterion for transferring young people to adult care disregarding factors such as self-independence and readiness for transition (Singh *et al.,* 2010). However, the Joint Commissioning Panel for Mental Health (2012) recommended that

commissioners should tailor transfers according to the needs of the most vulnerable groups including children with learning difficulties and young offenders. It follows that using age, as the only criterion for transitioning young people to adult services could be reconsidered.

The only argument for adhering to age cut-off criteria is that age boundaries aid organisational and structural purposes within services (Inspection CJJ, 2012). Adult services are structured differently to child services with the latter providing more routine-based milieus (Singh *et al.,* 2010). Barrow Cadbury Commission (2005) suggested using a life course approach integrating both adolescents and young adults, as it is unlikely that their needs significantly change once they turn 18. Although these recommendations refer to young adults in the criminal justice system, they can be extended to young people moving from forensic child to adult services considering that reaching a chronological age of 18 does not ensure entering to adulthood at a developmental level.

Davis (2003) explains that developmental transitions occur in the 16-25 age group and many of these young people are not ready for adulthood due to the complexity of their emotional needs. For example, young people diagnosed with learning disabilities and autistic spectrum disorders (Swift *et al.,* 2013) are not developmentally ready for such a transition. However, we currently lack empirical research on transitions of young people with learning disabilities and autistic spectrum disorders in contact with forensic services.

1.3.2 Transition delays

A recent systematic review on transition models, which included studies from the USA and Europe, highlighted that the most substantial difficulty in the transition process is inefficient communication between CAMHS and AMHS (Paul *et al.,* 2014). The Managing Transitions from Secure Settings project followed up six young people from secure settings in the UK (Hart, 2009). The findings showed that factors, such as housing and education, should be ensured for the young persons' return to their communities.

Transition looked the most discouraging factor since young individuals were notified about their placement even a day before their transition (Hart, 2009). Delays in transition within the youth justice system and lack of proper planning regarding new placements concurred with lack of coordination among services. The report illustrates that transitions within and across the justice system are rarely planned and usually occur at short notice lacking young person's proper transition management (Hart, 2009). Knowing the transition destination might be a protective factor for young people (Swift *et al.,* 2013) to avoid feelings of distress and insecurity. The findings highlight that young people need to have an active role in shaping their transitions, as they can acknowledge their own needs more efficiently.

One of the common reasons that accounts for transition delays is lack of bed availability in secure hospitals. As a result, long waiting lists turn transition into a confusing experience for young people. Bed shortage along with services infrastructural weaknesses can severely interrupt the transition process. When an initial placement has been identified and responding services cannot provide a bed at the time of referral, new referrals and discharge plans have to take place resulting in additional transition delays (Kane, 2008). Meanwhile, young people's mental health might exacerbate and new problems arise, such as risk; the young person might become more aggressive and the level of security they were referred to might not be appropriate anymore. An effective and structured post-discharge plan necessitates prior knowledge about the post-transition placement and failing to provide such information impedes young persons' commitment to future plans.

The Royal College of Nursing (2008) recommend that young people are allocated a reasonable amount of time to adapt to the idea of transition that means the young person should have a say on the transition period. Yet, the concept of *reasonable amount of time* is not definite and could vary depending on the case. For instance, some young people might need more time to prepare for the prospect of a transition depending on their mental health problem, risk and neurodevelopmental circumstances.

1.4 Rationale

It is widely accepted that adolescence is a risk period for the emergence of mental disorders. Yet, inadequate mental health care support during transition heightens the gap between child and adult mental health services (Davis, 2003). It has been reported multiple times in the current literature that young people with mental disorders undergoing adversarial transition experiences compose an extremely vulnerable group exposed to disjointed services (Singh *et al.,* 2010).

It is well established in the literature that transitions from child mental health services to adult services are challenging for young people in the UK. There is strong evidence that certain factors such as long waiting lists, adult services inflexibility, lack of proper staff training and rigid referral criteria hamper the transition process across services (Singh *et al.,* 2010).

NHS England (2015) identifies the transition process from child mental health services to adult services as being a risk factor to the mental health of young people. In the same service specification document, NHS England reports that those young people not experiencing a positive transition are more likely to have poor education outcomes. For instance, many of the young people admitted to forensic inpatient services have dropped out from school or their neurodevelopmental level lags behind their chronological age. However, a consensus in the literature has not been reached yet about which approach should be adopted choosing between improving current child mental health services and adult services or a new strategy of *youth mental health service* (Brodie *et al.,* 2011).

Young offenders in medium secure units experiencing transition to adult mental health services comprise an extremely distinct subgroup of this population with different needs and care-trajectories (Wheatley *et al., 2013*). Hence, they should receive appropriate management by mental health and criminal justice services during the transition process. For example, most females in forensic services are likely to present with

emerging personality disorders (Hill *et al.,* 2014). Despite the prevalent rates of emerging personality disorders in this group, they do not qualify for forensic CAMHS if this is the only mental health problem. Once they turn into adulthood, they can be transferred to an adult medium secure unit (YJB, 2010). Hill et al., (2014) reports that female young offenders mostly present with severe features of emerging borderline personality disorder (BPD) such as self-harm and unstable mood. This group is considered to develop BPD into adulthood and, therefore, a review of adult services current service provision could be undertaken for this group.

Providing standardised care irrespective of funding sources for young people could improve transitions. As identified above, there are gaps in the transition literature with regards to child and adolescent forensic psychiatric populations, such as continuity of care and discharge outcomes. To date, only one study has considered issues surrounding forensic child and adolescent mental health services while the current literature acknowledges the adverse consequences of poor transitions across AMHS in community populations. More evidence-based research is needed to understand service users' and carers' experiences and expectations of the transition process. Additionally, there is paucity in long-term outcome research of young people discharged from secure hospitals. There is urgent need to map young people's care pathways and examine guidelines and policies underpinning these transitions. It is worthwhile to examine whether hospitals follow similar national principles or if successful transitions depend on the functionality and infrastructure of each secure hospital.

1.5 Overview of the thesis structure

The overall aim of this research study was to assess the transition processes and policies across all six medium secure adolescent units in England and to explore young people's needs and characteristics during times of transitions.

Chapter One Introduction is an overview of the thesis and sets out briefly the problematic nature of transitions and the need to carry out empirical research to address current gaps in the system.

Chapter Two A Literature Review of the Context of Transitions and the Infrastructure of Forensic Services provides an overview of secure services for adolescents in England and Wales and unravels the problems embedded in transitions from forensic child and adolescent mental health services to adult services. This chapter also focusses on the gaps of the mental healthcare system and the lack of continuity of care as being addressed by
previous research in routine child and adolescent mental health services (CAMHS).

Chapter Three A Literature Review on Assessment and Psychopathology in young mentally ill offenders emphasises the higher rates of mental health problems in young people in secure care and the link between mental disorders and violent behaviour. The current literature emphasises that a group of young people is more likely to offend due to the presence of multiple risk factors in their lives and the absence of protective ones. This chapter describes the link between trauma, abuse and offending.

Chapter Four Methodology and methods present the methods and the underlying epistemological approach of this project. Each study is summarised and outlined separately including rationale, aims and objectives. I delineate the methods used to collect and analyse data. Last, I describe the ethical considerations when conducting research with this group of young people.

Chapter Five Mental health problems in adolescent offenders: a systematic review and meta-analysis expands on the prevalence of mental health problems among young people in secure settings. This study consisted of a systematic review and meta-analysis including a broader group of young offenders within the youth justice system whilst the

following studies focussed on a subgroup of this population including young offenders within forensic child and adolescent mental health services. The systematic review offers a general overview of the prevalence of mental health problems in the general offender population within the youth and criminal justice system and sheds light on the magnitude of the problem. Young offenders in transition comprise a sub-population of the general offender group belonging to a specific category. By establishing the significance of mental health problems' epidemiology among young offenders in contact with the youth justice system helped to understand the needs of the most vulnerable subgroup, which are those in secure services. The existing literature does not include studies on the prevalence of mental health problems of young people in secure hospitals or community settings to perform a systematic review.

Chapter Six Mapping transitional care-pathways among young people discharged from forensic child and adolescent mental health services presents the findings from using a mapping tool initially designed for the TRACK project (Singh *et al.,* 2010)-that evaluated transition services from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) in Greater London and the West Midlands. This mapping exercise was amended accordingly to capture the needs of the current project and to respond more efficiently to this study's objectives. This study examined what mechanisms are in place during the transition process for the young persons regarding transition planning and management. An important goal of the mapping exercise was to identify young offenders who should be moving to adult mental health services, custody and community as they had reached or were close to the transition age boundary (17.3 to 19 years) within a six-month timeframe, between 31st May 2016 to 30th November 2016. The mapping exercise was the key element that helped to proceed to the next stages of the project.

Chapter Seven Transitional pathways among young people discharged from forensic child and adolescent mental health services: a case note review included young people transitioning to adult services in the past

year providing important information on transition policy and procedures. These case notes included young people who moved to adult services and the community the previous year (30th May 2015-1st June 2016) and composed a nationally representative cohort to compare outcomes with ongoing transitions deriving from the mapping exercise. This study examined the transitional needs of young people by focussing on their characteristics and transition pathways.

Chapter Eight Exploring the transition experiences of young people, families and healthcare professionals across forensic child and adolescent mental health services presents the findings from face-to-face interviews conducted with the identified eligible young people undergoing transition across services. The interviews aimed to examine the impact of transition on young people's psychological well-being. Healthcare professionals (including responsible clinicians, consultant psychiatrists, clinical psychologists, nurses, social workers, healthcare support workers and occupational therapists) across all six forensic FCAMHS and adult services were interviewed to explore their experiences and to learn the structural and organisational components of transitions from forensic hospitals and community accommodations. Responsible clinicians and nurses consisted the key persons in the young person's direct environment whilst in child and adolescent secure services. A few parents were interviewed about the prospective transitions of their children. Therefore, these interviews were analysed in depth to understand these families' transition experiences and views.

Chapter Nine Discussion and Conclusions discussed the findings of the studies in line with the existing literature. This chapter also includes recommendations for transition policy and clinical practice in secure care and suggests pathways for future research based on the current findings. The original empirical contributions of this research study are set out.

2 A literature review of the context of transitions and the infrastructure of forensic services in England

"Institutional transitions are mediated by bureaucratic and legal, rather than cultural or natural, guidelines."

(Davis, 2003)

2.1 Chapter overview

This chapter provides an overview of the context of transitions for young people across generic mental health services, the criminal justice system and forensic child and adolescent mental health services in the UK and presents the relevant literature. This chapter entails setting sections on the types of transitions and a critical literature review that aims to introduce the reader to the magnitude of transition problems and to shed light on the infrastructure of the national secure services system for young people in contact with the youth justice system. I will focus on transitions in the mental health care system including forensic and general services.

2.2 Types of transition and the infrastructure of services

2.2.1 How is transition defined in the healthcare system?

For the purposes of this chapter, transition will be defined as proposed by the Department of Health (2006):

"a purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions as they move from child-centred to adult-oriented health care systems."

Paul and colleagues (2015) describe transition of care as any kind of

transition within and across the healthcare system without taking into account age criteria. According to this definition, the transition process begins with preparation from the old service and ends with the patient moving to the receiving service. However, the transition of care is an ongoing process in the healthcare system and depends on the needs of the patient population. Joint working between and across services is essential to achieve optimal transitions and minimise emotional harm for patients. Transition can be seen as an individual and team process including dynamic components that affect the patient and the system surrounding the patient such as healthcare professionals and family.

2.2.2 The three levels of transition

Transition could be threefold either developmental, healthcare related or situational (Singh *et al.,* 2010). Transition is not simply a transfer across services; instead it signifies a new "stage" in a young person's life underlined by several changes (Singh *et al.,* 2010).

2.2.2.1 Developmental Transition

Adolescence can be seen as an age but also as a developmental stage (Singh *et al.,* 2010). Adolescence is a critical period wherein young people undergo several changes that pertain to peer and personal relationships, family, housing, financial hardships, pregnancy and education (Ryan and Tunnard, 2012). Nonetheless, services adhere to age boundaries and 18-year-olds move to adult services even if they are emotionally unready for such a transition (Davis, 2003). Age boundaries are not tailored to young people's needs instead they facilitate bureaucratic and funding mechanisms of the health care system. It has been reported that young people are at the greatest risk of the emergence of mental disorders just at the stage of transition from child to adult services (Paul *et al.,* 2014).

2.2.2.2 Healthcare transition

Healthcare transitions often overlap with institutional/organisational transitions. There are several transitions within the health-care system for

young individuals with chronic diseases, learning disabilities, and mental health problems. The most important component of health-care transitions is multi-agency collaboration ensuring the young person's smooth transition preparation and management (Singh *et al.,* 2010). Davis (2003) states that health-care transitions occur in the 16 to 25 years group and many may not be not emotionally and socially equipped to move to adulthood. Therefore, rigid age boundaries may ignore young people's multi-level and complex needs.

2.2.2.3 Situational transition

Situational or institutional transitions pertain to transitions across community/home and independent/residential accommodations. Davis (2003) reports that child services are meant to respond to children's needs and adult services to adults' needs. Yet, the gap is heightened between chid and adult services with the lack of available services to support young people in transition. Young people moving to the community from inpatient child services have stayed for long-periods in highly structured environments, such as psychiatric wards and/or secure hospitals. Hence, they lack essential adult skills in terms of managing an independent lifestyle (Davis, 2003). Therefore, community transitions would be greatly improved by delivering educational and vocational training to prevent relapse.

2.2.3 What is the definition of forensic mental health services?

For the purposes of forensic mental health services, the following definition from the *Healthy Children Safer Communities* strategy project is used:

"Forensic mental health services provide assessment and treatment interventions for young people with complex, persistent or serious mental health disorders associated with high risk or offending behaviour. These interventions can be provided in community, residential and custodial settings." (YJB, 2010:10)

Harvey et al (2015) define forensic services as those accommodating high-risk offenders presenting with multiple needs. There are several pathways a young person might go through before ending up in a forensic setting where their needs can be met properly.

2.2.4 The 'young offender' in the context of the UK law

The Centre for Mental Health provides the following definition for mentally disordered offenders (Khan, 2010: p.14):

'The Crown Prosecution Service uses the term 'mentally disordered offender' to describe a person who has a 'disability or disorder of the mind' and has committed or is suspected of committing a criminal offence. This term covers a range of offences, disabilities and disorders. A mental disorder may be relevant to:

- *the decision to prosecute or divert;*
- *fitness to plead;*
- *and sentencing/disposal.'*

Young persons under 18 years in contact with the youth justice system share similar characteristics and backgrounds including: sexual offending, emerging personality disorder and/or severe mental disorder, fire setting being looked after child (LAC), learning disabilities, communication and/or speech and literacy problems, and school failure (Dent *et al.,* 2013). Young people in contact with the justice system and mental health services fall in the intersection of several legislations, such as the Children Act 1989 and 2004, Mental Health Act 2007, Mental Capacity Act 2005, amended 2007, Crime and Disorder Act 1998, Criminal Justice and Immigration Act 2008, and Education Act 2011 (Dent *et al.,* 2013). Therefore, the transitions become even more complex for mental health services. Their care is spread across several services: mental health, social care, criminal justice and education (Harvey *et al.,* 2015). Hence, the complexity of potential pathways depends on multiple-services' involvement alongside the young people's multilevel needs requiring a compounding care model. Attention should be drawn upon the fact that these services function by distinctive

mechanisms and also have different missions including funding schemes and legislature leading to variable treatment strategies (Harvey *et al.,* 2015). Social services, education and the justice system follow different funding streams, legislation and governmental affiliations; nonetheless these services have to work jointly in the best interest of the young person. The problem is that each system has different goals and interests that come in conflict.

2.2.5 Young offenders in secure settings

There are three types of secure estate for young people in the UK: Local Authority Secure Children's Homes (LASCH), Young Offending Institutions (YOIs) and Secure Training Centres (STCs). Offenders under 18 are also categorised as juvenile offenders and are detained in LASCH until they reach 15 years when they move to YOIs, which are prisons for young people, or STCs that include young people up to 17 years (Day, 2008). SCHs may operate as welfare accommodations for looked after children (Day, 2008). STCs are private institutions and accept both males and females in contrast to YOIs that they accommodate boys only.

Youth Offending Teams (YOTs) take over young offenders either in custody or community and provide help with educational and legal services. YOTs were developed in line with the Crime and Disorder Act (Gunn and Taylor, 2014). The Ministry of Justice states that an offender can remain in YOIs and STCs until 22 years and still be classed as a young offender (YJB, 2012). The vast majority of young people are detained in YOIs (Shodgrass and Preston, 2015). The Prison Service defines juveniles as those between 15 to 17 years and young prisoners as those between 15 and 21 years (Rickford and Edgar, 2005). In this *chapter young offenders with mental health problems are defined as those aged between 17 and 20 years with ongoing mental health problems in detention, hospital or community orders and experiencing transition across the criminal justice and mental health systems.*

2.2.5.1 Young offenders in secure hospitals

Young offenders in inpatient FCAMHS-secure hospitals comprise a distinct group that needs specialised treatment in hospital due to mental disorder presentation and high risk. This group of youth has offended, is either sentenced or not, has an emerging or established mental disorders and is detained under the amended Mental Health Act (MHA) 2007 and, specifically, under parts II or III (Bradley, 2009). Young people transferred to secure units under part II have not committed an offence per se but they might be considered a risk to self and/or others. Young persons detained under part III have offended and could be transferred from prison settings to inpatient units due to need of psychiatric care (Board, 2013). Yet each case might be far more complicated to be classified by MHA sections.

Young offenders with learning disabilities cannot be detained under the Act unless they present with violent behaviour (Dimond and Chiweda, 2011). Young people with substance and/or alcohol abuse problems are excluded from the MHA unless their dependence coexists with a mental disorder.

2.2.6 Overview of forensic child mental health services in England and Wales

There are several private and public sector organisations that provide forensic mental health services for adolescent young offenders in England and Wales. Mental health services could be either prison in-reach or inpatient services in low and medium secure hospitals. Some young people in custody receive treatment from community-based forensic teams such as Child and Adolescent Mental Health Services (CAMHS) that provide in-reach prison services (Hoare and Wilson, 2010). The National Secure Forensic Mental Health Services for Young People (SFMHSYP) is responsible for providing inpatient services to young offenders (Dimond and Chiweda, 2011) until they reach 19 years of age and liaises with CAMHS and AMHS along with the criminal justice system (NHS Commissioning Board, 2013). Yet young persons in full time education can remain in services up to 21 years.

SFMHSYP is also responsible for ensuring that the transition process to adult services is well suited to the young person's needs through proper collaboration with local agencies (NHS Commissioning Board, 2013). In addition, SFMHSYP should ensure that the young people are treated in line with the Care Program Approach (CPA) agenda, which means that they will have access to a primary nurse, social worker, occupational therapist and psychologists enhancing a Multidisciplinary Team (MDT) model approach (NHS Commissioning Board, 2013).

In England and Wales, there are currently six medium secure units for adolescents with mental health problems, providing 68 inpatient- beds (YJB, 2010) commissioned by the National Commissioning Group (NCG). It is reported that the NHS provides commissioning for 100 beds of which 27 beds are for young people with for learning disabilities (Snodgrass and Preston, 2015):

- Ardenleigh Unit (Birmingham),
- Gardener Unit (Manchester),
- Malcolm Arnold House (Northampton),
- Alnwood Unit (Newcastle),
- Wells Unit (West London),
- and Bluebird House (Southampton).

Young offenders aged between 12 and 18 years who meet the eligibility criteria (detained under the Mental Health Act 1983) are referred to medium secure adolescent units through the National Commissioning Group (NCG) transferred from YOIs, STCs, and Local Authority Secure Children's Home (LASCH) (Dimond and Chiweda, 2011). A qualified psychiatrist needs to make the referral to secure services (DH, 2013). If a young person is considered high risk and presents with severe mental disorder symptoms, they are moved to inpatient units (YJB, 2013). According to the NHS Commissioning Board (2013), admissions to medium secure adolescent units should take place within 7 to 14 days from referral; in case of emergency the transfer should not take more than 7 days.

However, this is not the case for young people in youth custody as several delays occur even for groups considered high risk for secure services (Centre for Mental Health, 2011). The Centre for Mental Health (2011) has reported that eligibility criteria for admissions in secure hospitals are quite rigid and the Mental Health Act-based on severity of diagnosis and offence type- provides the only criterion for acceptance to such services.

Young offenders with a diagnosis of severe mental illness such as psychosis and/or emerging personality disorder are accommodated at medium secure units and no high secure services are provided for this group. The majority have been diagnosed with behaviour and emotional disorders in the past along with substance use (Withecomb, 2004). A diagnosis of 'emotionally unstable personality disorder' is quite common among female young offenders (Hill *et al.,* 2014). Individuals with learning difficulties are referred to specialist mental health units including ex-Malcolm Arnold House/current Fitzroy House and Alnwood clinic specialising on their particular disability needs. Malcolm Arnold House is part of St Andrews Healthcare that does not belong to NHS. However, NCG funds forensic patients with neurodevelopmental disorders; what is an issue of concern though is these patients' length of stay in the unit, as their long-enduring problems along with the lack of appropriate downgrade services predicts long-term stay (YJB, 2010). Adult services may not provide adequate care for persons with learning disabilities and neurodevelopmental disorders.

A central record for low secure units does not exist and, therefore the number of beds available remains unknown (Schodgrass and Preston, 2015). Low secure services admit young people under the Mental Health Act through court and hospital orders. The first NHS low secure unit for adolescents opened in 2004- the Westwood Centre, in northeast England. A study looking at profiles of young people admitted in the first 45 months, found that 11% of the population detained were referred from secure settings and 4% from courts (Nadkarni *et al.,* 2012). The patients' profiles-regarding mental disorder diagnosis does not differ from those in medium

secure units, as most young individuals are diagnosed with psychotic or affective disorder and emerging personality disorder (Nadkarni *et al.,* 2012). However, the level of dangerousness and risk of harm to self and/or others might be different and determine the level of security the young person requires. Low secure units admit young people with 'non-forensic presentations' but still with multiple needs and complex behaviours such as self-harming (NHS England, 2015).

Community FCAMHS across England and Wales are not standardised yet although attempts have been made to have a standard specification regarding service provision and assessment (NHS Commissioning Board, 2013). Furthermore, effective liaison among youth court services, CAMHS and YOTs, is imperative in order to improve mental health services and to develop a scheme that responds to the young individuals' needs (Nacro, 2006). There is an increasing need for community provision and multiagency collaboration as healthcare professionals admit that young offenders can be detained in forensic mental health units for unnecessary prolonged periods due to inadequate community care services (Hoare and Wilson, 2010).

Unfortunately, community FCAMHS do not respond efficiently to young people's needs due to several problems. Community FCAMHS are not nationally funded as medium secure units, resulting in inadequate service provision (Dent *et al.,* 2013). For instance, community FCAMHS are not available for young individuals in many geographical areas across England and Wales. Working with community FCAMHS more efficiently would greatly benefit and facilitate transitions in the community, as young people would take advantage from consistent care tailored to their particular mental health and psychosocial needs.

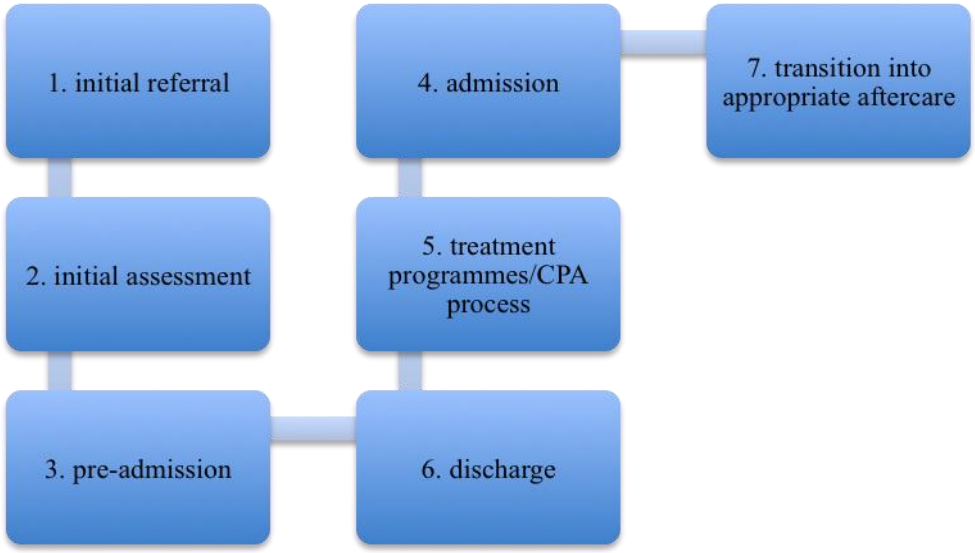
Psychiatric intensive care units (PICU) are similar to low secure regarding the nature of clinical cases. However, PICU do not provide the same level of educational services and activities as low secure hospitals (NHS England, 2015). Again, PICU admit young people with forensic and non-

forensic backgrounds. This form of inpatient services accommodate those young people who cannot be managed in outpatient settings due to challenging behaviours.

Table 1. Eligibility criteria for acceptance to medium secure adolescent units (NHS Commissioning Board, 2013)

Inclusion criteria All referrals are selected for assessment according to nationally agreed criteria: • the young person is under 18 years of age at the time of referral; AND • the young person is liable to be detained under either Part II or Part III of The Mental Health Act 1983. In addition: EITHER • the young person presents a significant risk * to others of one or more of the following: - Direct serious violence liable to result in injury to people, - Sexually aggressive behaviour - Destructive and potentially life threatening use of fire OR -The young person in custody (remand or sentenced) is in need of inpatient hospital treatment for mental disorder AND • There is clear evidence that serious consideration, and testing where appropriate, of alternatives has already been tried prior to referral, indicating that the case has exceeded the ability of available mental health services to meet the need. * It is not necessary that the referred young person should be facing criminal charges for these risk behaviours, but it is necessary that there should be reliable accounts available of such behaviour **Exclusion criteria** Patients who are not eligible for this service are those: -Young person referred after 18 years old -patients whose primary diagnosis is Learning Disabilities -the patient's condition is such that they would be more appropriately served by e.g. Low Secure hospital

Figure 1. Referral pathway for young people admitted to mental health settings (NHS England, 2013)



2.2.6.1 The legal framework underpinning forensic CAMHS

The Mental Health Act integrates the relevant law that links mental disorders with offending. The Mental Health Act often works in line with the Mental Capacity Act (2005) when a young person, 16 or 17 years, lacks capacity to make informed decisions regarding their treatment.

Up to recently, the Mental Health Act 1983 was used for young people in secure mental health care and/or detention settings. According to the amended Mental Health Act, 2007 children are considered those below 16 years and young people those between 16 and 18 years (Street, 2008 in Kane, 2008). One of the major amendments (section 31) of the Mental Health Act 1983 was that hospital managers are responsible for placing young persons in environments that are appropriate for their age and health care needs to avoid admissions of underage patients in adult hospitals (Singh *et al.,* 2010). Young people, in conjunction with section 131A, should receive proper care that meets their psychological, physical, educational needs (Kane, 2008). The literature reports that adolescents admitted to adult inpatient hospitals due to lack of available community placements and adolescent inpatient beds are more likely to be isolated, unsafe, abused and to experience future chaotic transitions (Brodie *et al.,* 2011).

A young offender detained under parts II or III of the MHA cannot refuse treatment and only the responsible clinician, hospital manager or tribunal can discharge them (Mental Health Act, 1983). Part II of the Act includes those individuals detained in hospital for assessment and those young people having committed a minor crime or not, such as carjacking or shoplifting, or who are considered high risk for themselves or others. However, patients under this part can also be treated for their mental disorder under section 3.

Part III refers to those individuals detained in hospital for treatment on pre-trial status and are either sentenced or not sentenced; they could be held under section 37, 38, or 41 or 37/41. This part can extend to six months and then renewed every 12 months (Kane, 2008). Section 37 falls under part III and is called ‘section 37 hospital order’ and an offender can be detained for six months. If the responsible clinician deems that the person needs further treatment it can be extended to another six months (Mental Health Act, 1983). Section 37 applies to those offenders ‘unfit to stand trial’ or ‘unfit to plead’ due to their mental state and instead of prison sentence they are assigned hospital admission. This group has a mental disorder or severe mental impairment and present violent behaviour excluding those young people with learning disabilities. An offender under this section has to be assigned a guardian who will be responsible for their treatment and should be an approved mental health professional (Mental Health Act, 2007). The Crown Court can place an offender under a hospital order either if they are convicted or not, whilst the Magistrates’ Court can only bring under hospital order an already convicted offender. Section 38 is called ‘interim hospital order’ and includes sentenced young persons who need hospital assessment.

Section 41 is a ‘restriction order’ imposed by the Crown Court that deters discharge from hospital. When the court deems that the offender is dangerous to the public and in risk of reoffending, then section 41 is forced (Mental Health Act, 1983). A young person under section 37 can be also

detained under section 41 that is 37/41. Further, section 47/49 refers to sentenced inmates transferred to hospital from prison due to their mental health needs and is known as a ‘transfer direction’ meaning that the Secretary of State remains responsible for the young person throughout the process until the ‘release date’ (DH, 2013). Specifically, section 49 is called ‘restriction direction’ because it works similarly to section 41 regarding hospital discharge rules. Section 48 pertains to non-sentenced prisoners sent to hospital either under section 49 or not.

According to 50, 51 or 53 of the Mental Health Act, young offenders can return to custody if the responsible clinician considers they are mentally fit for discharge or there is not any appropriate treatment that applies to their case (DH, 2013. If they are still unwell they might remain in hospital ‘past release date’ (prison sentence has finished) or be transferred to another hospital under section 37 ‘notional’ (Mental Health Act, 1983). Notional 37 is not an official section of the MHA rather it is applied casually. If the young person is under 18 years, they will often transition to the same establishment they were in before being admitted to the secure unit. However, if the person has reached 18 years whilst in hospital, then the S117 meeting members seek to find an appropriate setting for the young individuals’ needs (DH, 2013).

Section 117 refers to ‘aftercare plan’ that is required for young people who have been accommodated in secure hospitals (DH, 2013). This section mandates that CPA should be implemented according to the young person’s mental health needs. According to section 117, health and local social agencies should manage an aftercare-plan for people detained or transferred under section three until they are considered ready to move from the care of such services (Young Minds, 2011). Healthcare professionals from the receiving service have to participate in the pre-transition meeting in order to follow transition plans and preparation (DH, 2013).

The Mental Health Act 2007 included a supplementary amendment and presented Supervised Community Treatment (SCT) where patients could be transferred to the community and receive treatment there if they are detained in hospital under part III and section 3.

2.3 Literature review on transitions

2.3.1 Evidence-based research on transition of care from CAMHS to AMHS

The TRACK study, one of the largest national studies on transitions from general CAMHS to AMHS, demonstrated that 23.5% young individuals with neurodevelopmental disorders including ADHD and Autism Spectrum Disorders (ASD) were not accepted by adult services (Khan and Wilson, 2010). Research highlights that healthcare providers lack training to treat individuals with ADHD (Hall *et al.,* 2013). Previous research on transitions highlights that AMHS are resistant to accept individuals with affective disorders along with self-harming behaviour (Khan and Wilson, 2010). ADHD is commonly diagnosed among young people in contact with the criminal justice system alongside conduct disorder and proper treatment seems vital. The possibility that AMHS will not accept young people with such mental health problems increases the gap between the two agencies.

Nonetheless, young individuals with a diagnosis of psychosis receive Early Intervention Services (EIS) and transfer to AMHS. Accordingly, some of the most significant criteria to be accepted by AMHS include prior hospitalisation, being on psychotropic medication, and having a severe and enduring mental health illness (Young Minds, 2013). From the TRACK study sample it is worth noting that only about 4% experienced optimal transition. Dual diagnosis, - substance abuse along with a concurrent mental disorder, composes an additional barrier to accessing proper treatment, as the needs of individuals who fall into this category remain unmet.

Another problematic area of transitions is the absence of shared transitions protocols across trusts (JCPMH, 2012). The JCPMH (2012) highlights that

some protocols are well designed and enhance the transition process whilst others are too vague to be effectively used and implemented by services. Singh and colleagues (2008) noticed that many transition protocols do not recommend specific preparation pathways for young people. The authors also reported that protocols did not share similar policy about transition planning and liaison amongst services.

NHS England (2015) has released a protocol-specification document that contains all essential components of a successful transition from child mental health services to adult services. This protocol underscores the importance of multiagency collaboration pre-during-and post-transition. It acknowledges that transitions for young people are of paramount importance to their well-being and negative experiences along with services' disruption could inhibit smooth transition through services. NHS England (2015) recommends ongoing care and assessments aiming to providing a multidisciplinary approach to treatment with continuity and consistency of care.

The Joint Commissioning Panel for Mental Health (2012) recommends that commissioners should design transitions by drawing attention to children with learning disabilities and educational problems and/or with chronic medical diseases, and also young offenders. These groups have been identified to be more likely to have poor transition outcomes. The same report has acknowledged that several services across England have made efforts to bridge transitions gaps.

2.3.2 Family involvement and sustained relationships

The role of the family throughout the transition process has been discussed multiple times in the current literature (Swift *et al.,* 2013). Families should be an integral part of transitions and their involvement is significantly important. Most young persons are attached to their families and the young persons' recovery sometimes partially relies on the family's role (Kane, 2008). As Swift et al. (2013) highlight, parental involvement might be necessary at the early stages of transition to AMHS. However, the case

might be different for certain cohorts of young people and young offenders, in particular.

Young people involved in the youth justice system often come from families lacking secure attachment and, parents refuse to be involved. Further, many young offenders are looked after children and have spent time in foster care. As Kane (2008) reports, relationships with staff and healthcare professionals in inpatient hospitals might be the only sustained relationships young people ever had. The transition to adult services might perpetuate the pattern of inconsistent relationships in these young people's lives. Accordingly, attachment is a key element in the transition process, as previous research has addressed (Kane, 2008).

Abrupt transitions where the young person loses relationships with staff and attachment to places can severely interrupt a smooth transition. Adult hospitals do not rely on attachment theory as child services do (Kane, 2008). Therefore, transferring to adult hospitals can potentially traumatise young people, as they have to cope with new care models. Child services should liaise with adult care and work collaboratively on managing effectively attachment, loss, and transition. Young people in contact with forensic services are more likely to have experienced loss in the form of bereavement, contact with their families and parents and friends, termination of relationships with key figures (Day, 2008).

2.3.2.1 Transition experiences for service users and their families

A recent research briefing identified the major problems underlying transitions to adult mental health services describing the young people's experience of transition process as confusing and difficult (Brodie *et al.,* 2011). Likewise, there was much confusion surrounding the role of child and adult services while service providers reported organisational and service inconsistencies. The family/caregivers or the young individuals expressed that they lacked understanding of the transition process. Legal processes and multiple service involvement along with the plethora of different types of services can lead to poor transition outcomes with

confusion stemming from the different policies underlying child and adult mental health services bring confusion (Vyas *et al.,* 2015). Parents and services users have described services as unpredictable where their personal views and experiences remain invisible and overlooked (Brodie *et al.,* 2011).

CAMHS accept young individuals with learning disabilities, self-harm, affective and conduct problems, and also severe mental illness. Child services historically have adopted a psychosocial approach taking into account developmental changes that emerge during adolescence (Vyas *et al.,* 2015). On the contrary, AMHS accept primarily those with severe and enduring mental illnesses embracing a biomedical approach (Lamb and Murphy, 2013) leaving people with neurodevelopmental problems, eating disorders and emerging personality disorders without adequate service provision. In addition, when young people reach 18 years, services do not have to engage families in treatment resulting in family disengagement from services (Singh *et al.,* 2010).

Similar issues arise within the youth justice system and transition to adult services. Research on transitions from YOTs to probation trusts have showed that most cases eligible for transfer were not referred because the YOT workers deemed that adult services will not provide adequate care for young persons with mental health problems (Inspection CJJ, 2012).

2.3.3 Continuity of care

Continuity pertains to sustained relationships as shaped by the experiences of the young person (Burns *et al.,* 2007). There are four elements embedded in continuity of care: relational, longitudinal, flexible, and effective communication (Byng *et al.,* 2012). Relational continuity refers to therapeutic relationships while longitudinal continuity concerns sustained relationships with the same healthcare team in the community. Flexible continuity responds to a broad variety of needs and effective communication is facilitated through confidentiality and multiagency collaboration.

Discontinuity of care could often result from services' inconsistency and fear of stigma among young offenders (Paul *et al.,* 2014). Young offenders' experiences in custody and other agencies have caused insecurity and stress in their lives hampering dependable relationships with primary mental health professionals (James, 2013). Lack of trust and inconsistent relationships with healthcare professionals inhibit help-seeking behaviours and individuals may choose to disengage from mental health services (Byng *et al.,* 2012). Thus, to avoid disengagement from mental health services, health care providers should invest in building long-term relationships that enhance trust (Bradley, 2009). The Bradley report recommends feedback from service users promoting dynamic involvement of young offenders to target discontinuity and disengagement.

The Young Minds (2013) report identified similar barriers to continuity of care in transitional care, such as infrequent contact with GPs and inconsistent relationships with healthcare professionals that seems to be of paramount importance in various studies across the literature (Burns *et al.,* 2007). Continuity of care predicts stability and trust, which are usually two features absent from young offenders' lives.

A recent study conducted by Campbell and colleagues (2014) using a small sample of young people from different tiers of the justice system in the UK confirmed the shortcomings of transitional care. Continuity of care was cited several times predicting less trusting relationships between service providers and young offenders. Harrington and colleagues (2005) found that only 30% received support from services. The study concluded that services were unable to provide support with regards to relationships, education, and mental health. These factors should be addressed before discharge to the community to enhance autonomy (National Institute for Care and Health Excellence, 2015) and reduce the risk of reoffending.

Only one study included young females who had moved from adolescent medium secure units to adult medium or low secure units in the UK (Wheatley *et al.,* 2013). This group involved eight patients who had experienced transition during an 18-month period. Yet, only those moved to lower secure units seemed to have positive experiences while others felt intimidated by the aggressive behaviour of older patients. Potentially, moving young people from child inpatient services to an adult ward with older patients might exacerbate their mental health symptoms.

Young people present with different needs than older patients who have been in the system for a while and might not compose role models for newly admitted patients. Findings from the same study suggested support from key workers was an emerging theme that is common in other transition studies (Campbell *et al.,* 2014). More research is necessary to explore the experiences of young offenders moving to adult services in distant geographical areas (e.g. far from home or from forensic child services).

2.4 Conclusions

Transitions from forensic child and adolescent health services entail numerous difficulties that can severely distress young individuals. Young people in contact with forensic mental health services experience a broad range of challenges, from multiple interfaces with the legal system, untreated mental health problems leading to poor transition outcomes. They also struggle with lack appropriate housing, non-existent family support networks and lack of employment opportunities. Psychological problems per se do not compose the only factor contributing to poor mental health (Young Minds, 2013). Therefore, multidisciplinary collaboration across services may significantly help young people to overcome the inherent transition difficulties (Swift *et al.,* 2013).

In addition, there is a need to address the particular needs of this vulnerable population, such as young offenders with ongoing mental health problems, and track their care pathway in order to improve current care

models that will turn transition across agencies to a well-adjusted experience. If the needs of individuals with serious mental illness and co-occurring mental disorders are not met when returning to their communities, the risk of reoffending increases with subsequent return to custodial settings (Wilson *et al.,* 2011). Exposure to risk factors increases the likelihood of offending (Ryan and Tunnard, 2012). The ultimate goal is to detect mental health problems earlier than these young people come into contact with the youth justice system (DH, 2009). Some young persons can be discharged to the community where they have to follow-up with outpatient mental health services or forensic community-based teams that adopt different care models from secure hospitals for adolescents. These young people may need help in planning transitions and learning how to build an independent lifestyle in order to manage housing, employment and mental health symptoms. Accordingly, increased knowledge on current processes and policies may improve transition outcomes.

There is also consistent evidence from previous studies with ex-young offenders released in the community that mental health symptoms persist until later in life. One recent study has shown that nearly up to 50% of young persons in the community with a forensic background have mental disorders (Harrington *et al.,* 2005). The link between mental health problems and criminality in young offenders has been widely accepted by the research community (Grisso, 2008). Further, other studies have shown that children released from custody back to the community are more likely to use alcohol and substances (Dent *et. al.,* 2013). De-escalation of reoffending should be the primary goal targeted by services whilst young people experience transition. When transition turns into a risk factor due to services' infrastructural problems and lack of proper care-pathways, then the risk of recidivism is elevated as well. However, before improving and designing services and delivery of care, there is a need to establish the magnitude of mental health problems and needs in young people accommodated in secure care. The next chapter examines mental health problems and the links to violent behaviour in this group.

This critical review of the literature identified a paucity in research pertaining to transitions of care across forensic child and adolescent mental health services and youth justice services. Currently, there is little information on young people's discharge destinations and presenting needs at a national level. The policies and outcomes underlining transitions from FCAMHS remain unknown alongside the clinical and demographics characteristics of this group. Forensic inpatient services for young people are nationally funded services accommodating young people transferring from prison settings and psychiatric hospitals and detained under the Mental Health Act. Medium secure services provide the highest level of security for young people and are designed to admit those young people presenting with high- risk and being dangerous to others and/or themselves and having severe mental illness. The intersection between the nature of offence and psychopathology and young age makes this group particularly vulnerable to transitions and changes. However, there is lack of knowledge regarding transition processes and outcomes in this group. There is an increasing need to understand the context of young offenders' transitions and map their pathways in order to ensure that current service models are resourced adequately to facilitate smooth transitions. Therefore, this research study is will use four different phases to address to current gaps in the transition literature. This thesis will bridge the existing gaps of the literature through mapping and following up young people discharged from all six forensic child and adolescent mental health services (FCAMHS) to adult services and interviewing young people, healthcare professionals and families. A mapping exercise and a case note review will be used to identify the discharge destinations of young people and to map their care-pathways. Semi-structured interviews will be carried out to explore the transition experiences of young people, their carers and healthcare professionals to bridge the existing gaps in the literature identified in this critical review of the literature. The overall research question that will be addressed is the following: 'What are the processes, outcomes, experiences and characteristics of young people moving from FCAMHS to adult and community services?' The next chapter is a critical literature

review on psychopathology and crime and the specific research questions of this thesis will be set out in the end of the chapter.

3 A literature review on assessment and psychopathology in young mentally ill offenders

"…up to 92% of detained children, have suffered some form of physical or sexual abuse or neglect…The inner turmoil shows in behaviour sometimes shocking and repulsive-not as a sequence of any intrinsic defection or difference but because these children have been wronged."

(Willow, 2015: 27).

3.1 Chapter overview

This chapter is a critical review of the existing literature and acknowledges the variety of methods in assessing mental health problems among young offenders. Clinical assessment and its complexity are discussed early in the chapter alongside the significance of assessing resocialisation needs in young offenders. This chapter examines a wide range of mental disorders among young people in contact with forensic and criminal justice system and looks at the association between these disorders and offending and/or aggressive and violent behaviour. Young people in contact with the youth justice system and forensic child and adolescent mental health services (FCAMHS) present with a wide range of comorbid mental health problems and learning difficulties and/or neurodevelopmental disorders.

3.2 Risk assessment and resocialisation needs

Risk assessment is a multifactorial process predicting the likelihood of an event based on risk estimators (Hanson, 2009). Young people undergo risk assessments to identify their current needs based on present and past risk factors in place. Risk assessment is a complex process where clinical judgment plays a critical role in addition to the presence of risk factors (Scooner *et al.,* 2012). Risk assessments have been described as predictive tools whilst there is a debate surrounding the accuracy of these tools. However, these tools are essential and integral in the discharge process and, subsequently, in transitions to adult services. The level of

security a young person requires is determined partially from the risk assessment process where clinical, social and educational needs are addressed to determine the most suitable level of security or the most appropriate community placement for young people. Risk assessment also determines whether a young person could return to the community. Yet, this includes consideration of past offence, readiness to move to an independent lifestyle, risk of reoffending, and the views of the public and victim. There are cases, where the nature and severity of the offence cannot allow the young person's release to the community due to the public's outrage and the harm caused to the victim and their family. In some circumstances young people's mental disorder symptoms may have been stabilised, their risk significantly diminished, and they may have developed prosocial skills, but the harm they have caused to the victim and the society in general may affect their care-trajectory.

Research purports that there is conflicting evidence on risk and there is a divide between healthcare professionals and policy makers and societal views on risk perception (Kemshall, 2000). The implications of risk misperceptions are extended to young people's care-pathways and policy making alongside institutional processes. Healthcare professionals come across ethical dilemmas when they have to offer clinical judgment regarding a young person's release to the community. For instance, a sex offence instigates the dilemma between offender's rights and community safety (Scoones *et al.,* 2012).

To date, there are several risk assessment tools such as the Structured Assessment of Violence Risk in Youth (SAVRY) in an effort to identify high-risk groups (Borum, 2000). SAVRY is the most widely risk structured assessment tool that is organised according to scientific evidence prevalent in youth development. It is tailored for youth between 12 and 18 years tackling violent behaviour and reoffending and includes historical, social and clinical indicators associated with offending behaviours in youth (Welsh *et al.,* 2008). SAVRY differs from other risk assessment tools including the presence or absence of protective factors such as resilience (Welsh *et al.,*

2008). Research has shown high predictive validity in young populations, and this might be explained by the fact that the tool was initially intended to be used only with adolescents (Singh *et al.,* 2011). The majority of risk assessment tools focus on risk factors disregarding protective ones.

The strengths-based approach such as the Good Lives Model (GLM) purports that environmental factors, positive traits and skills are equally important to offenders' rehabilitation to the community (Scoones *et al.,* 2012). According to GLM, violent behaviour results from lacking prosocial internal and/or external means to meet personal values. For example, poor social circumstances and comorbid mental health problems can enable antisocial behaviour and offending. However, if this group is provided with prosocial resources, they will have the potential to desist from crime and reintegrate to the community. Therefore, GLM offers a different understanding of risk, as a dynamic factor, reinforcing release to the community. In contrast, policy makers have to ensure public safety and focus more on the outcome of the offence. Releasing an offender to the community, could negatively impact the victim's and community's wellbeing. The victim may have experienced trauma that could be re-activated at the prospect of the offender's return to the community. Research findings suggest that offenders who have received proper planning and moving to the community have been less likely to reoffend (Willis and Grace, 2009). Release to the community could disrupt the victim's recovery-in cases of abuse and severe assault and could increase feelings of powerlessness and exclusion from the criminal justice system. The community is also victimised by a crime, they are a *secondary victim* and their voices should be considered (Zehr, 2015).

The Risk Need Responsivity (RNR) model treats offending behaviour as a multifactorial process and could be used in a wide range of therapeutic interventions (Looman and Abracen, 2013). This model considers biological, social, cultural, personality and social factors resulting in criminality. RNR entails more factors leading to crime than the GLM that focusses primarily on the offender's strengths. Risk factors are paid equal

attention as protective ones and the offender is aware of the potential risks. This approach is more holistic and could potentially be embedded in therapeutic interventions before discharge to community settings. For example, those young people ready to move back to the community, as part of their transition from FCAMHS, could benefit from RNR. Research findings have shown that offenders are more likely to develop understandings of their risk if they have participated in RNR programmes (Looman and Abracen, 2013).

It has been reported that high-risk groups usually have an arrest history along with long-term hospitalisation (Douglas and Skeem, 2005). These factors are known as historical factors because they are static whilst dynamic factors are those that have the potential to change such as impulsiveness and treatment adherence. When a clinician is conducting a violence risk assessment both types of factors are relevant to clinical judgments.

3.3 Mental Disorder Definition in the youth justice system

The definition of mental disorders across young populations comprises one of the major challenges that pertain to the identification of mental disorders within this population. The criteria for diagnosis are still contentious and the factors that determine mental health status remain debatable (Shah, 2015). Grisso (2004) suggests three criteria for assessing mental disorders in adolescence: (1) the way developmental psychopathology classifies the categories of mental disorders, (2) severity of mental disorders and to what extent they interfere with the daily routine of young people, (3) how the youth justice system interplays with the concept of mental disorders to serve policy.

The degree of severity of the mental disorder determines the legal and treatment implications in young offenders since youth who meet the criteria for milder mental disorders do not always need treatment (Grisso, 2004). The diagnosis serves legal processes and outcomes and aims to facilitate the judicial system process resulting in the best available care plan for the

young person. However, conduct disorder and learning disabilities may hinder the process of receiving treatment despite comorbid mental health problems or cognitive deficits (Grisso, 2004). There are several stages in the youth justice system such as pre-trial or post-trial when young people need to be assessed to ensure that their needs are not missed.

Clinicians use diagnostic tools such as the DSM, ICD-10, and DISC for diagnostic purposes in young individuals. Different assessment tools have different diagnostic principles influencing the process of diagnosis, as there have not been established international diagnostic criteria that guide clinical evaluations (Richardson *et al.,* 2015). To date no evidence has been found that clinical assessment tools particularly tailored for offenders are more effective than those for the general population (Richardson *et al.,* 2015). Typical diagnostic tools for children such as the DSM-5 and the ICD-10 might disregard cultural differences and depend heavily on western norms and cultural imperatives overlooking cultural relativity (Belfer, 2008).

3.4 Assessing mental disorders amongst young offenders

Assessing mental disorders among young offenders can be extremely complicated. According to Grisso (2004), there are three factors that should be taken seriously into consideration when clinicians carry out assessments: availability, reliability and applicability. Availability refers to the methodological tools that are available and reliability on how credible they are. Applicability depends on the tools' usefulness on this specific population.

Two widely used tools in youth justice populations are the Diagnostic Interview Schedule for Children (DISC) (Schaffer *et al.,* 2000) and the Schedule for Affective Disorders and Schizophrenia for school-aged children Present and Lifetime (Kiddie-SADS-PL) (Kaufman *et al.,* 1996) while the Diagnostic Interview for Children and Adolescents (DICA) (Reich, 2000) is also utilized (Grisso, 2004). DISC is a structured diagnostic tool assessing symptoms of mental disorders in children and adolescents. The interview includes more than 30 diagnoses built on an DSM-IV algorithm

and ICD-10 diagnostic criteria (Lewin *et al.,* 2014). DISC-IV is the latest version and measures point and period prevalence within the last four weeks and the past year and also includes a section assessing impairment (Schaffer *et al.,* 2000). There are also parent and youth editions for young people nine to 17 years. K-SADS-PL is a semi-structured diagnostic tool assessing current and lifetime psychopathology in children and adolescents based on DSM-III-R and DSM-IV. One great advantage of this diagnostic instrument is that the interviewer is allowed to adapt the questions to the interviewee's developmental ability (Kaufman *et al.,* 1996). The PL version includes interviewing of parents as well. In case the scoring does not coincide, then the interviewer should use their clinical judgment to draw upon conclusive inferences. Yet, K-SADS-PL is designed to stress youth's internalising symptoms and parental observations for youth's externalised behavioural symptoms (Kaufman *et al.,* 1997).

However, most of the tools depend heavily on young people's or their parents' self-report measures. It has been reported that youth tend to express more effectively their internalised emotions and parents are efficient in observing behaviours namely in externalising behaviours (Grisso, 2004). Grisso (2004) points out that youth reports may be non-reliable owing to their lack of trust towards the justice system where young females may exaggerate their symptoms to gain more attention. This is an act of malingering where the young person aims to benefit from secondary gains of mental illness and be treated more favourably.

3.5 Malingering in the youth justice system

Malingering can play an important role to judicial processes, mental health treatment and transition destinations. Young offenders may exaggerate their symptoms or even pretend and act out a mental disorder to gain special treatment in forensic settings. This phenomenon could be seen as a conscious secondary gain where young people who have been in the system for a while, have attained good clinical knowledge to pretend and malinger their symptoms. Malingering can have serious implications on treatment outcomes, care-trajectories and, specifically, transitions.

Persistent self-harming can also be a form of malingering in order to demand enquires whilst in forensic settings. However, clinicians cannot overlook self-harming or treat it as a manipulative strategy due to safeguarding issues guiding forensic wards. Self-harming can be seen as malingering when *it is not internally induced* and is not driven by suicidal intent (Konrad and Opitz-Welke, 2014). Self-harming is often used to relocate in secure settings to a more desirable institution. Accordingly, in periods of transition, when young people are anxious about their prospective transition to community settings or to adult prisons, they might engage in self-injurious behaviours and /or malinger symptoms to be transferred to a more secure setting or avoid prison.

3.6 Crime and psychopathology: identifying protective and risk factors

Youth violence has been at the centre of etiological research for a long time and the extant literature has focussed on understanding the reasons underlining violent behaviour in young populations. Addressing the factors and motives of youth violent behaviour would increase the likelihood of designing more effective prevention programmes and improve current models of care that will tackle the problem (Hall *et al.,* 2012). Understanding the relationship between crime and psychopathology is critical for the design and development of care-trajectories and transition of care. Young people who engage in criminal and/or delinquent behaviour are more likely to have a mental disorder and, particularly conduct disorder problems that are characterised by antisocial acts. Research has shown that 95% of young people in prisons in the UK had at least one mental disorder corroborating that there is a link between crime and psychopathology in young populations (Lader *et al.,* 2000). These behaviours often derive from comorbid mental health disorders and may lead to risk taking behaviours and offending. Young people in early contact with the youth justice system have been transferring across various services such as forensic inpatient hospitals and secure settings such as Young Offender Institutions (YOIS). Their risk to society and other and/or

themselves in line with their mental health difficulties can determine their care-pathway. Those young people with the most complex needs will be transferred to forensic inpatient hospitals due to high risk, high harm and high vulnerability whilst others with less severe mental health symptoms can be treated within prison settings by the suitable healthcare team.

Mental disorders elevate the risk of engaging in offending behaviour and in particular, any mental disorder in morbidity with substance abuse increases the risk of violence (Grisso *et al.,* 2005). There is a link between crime and psychopathology, whilst young people with specific mental disorders such as conduct and oppositional defiant disorder (ODD) are more likely to engage in delinquent and offending behaviour. Yet, there are several precipitating factors associated with criminal and aggressive behaviour. Risk factors are indicators of future violence and adverse outcomes (Kim *et al.,* 2016). Hawkins and colleagues (2000) underscored the importance of family, peer-relations, school problems, community, and individual and personality factors. The authors include as individual factors also physical health issues such as pregnancy complications and heart problems, depression and anxiety disorder, alongside hyperactivity and aggressiveness. Other individual factors include gender; males are more likely to act violently compared to females who tend to manifest violence in different means such as verbal aggression (Herrenkohl *et al.,* 2000). Family factors include parents with criminal background, parental conflict, family environment endorsing substance abuse and violence and parental neglect and lack of family boundaries (Herrenkohl *et al.,* 2000). Young people from families reinforcing violent behaviour tend to imitate these behavioural patterns and act upon such norms (Herrenkohl *et al.,* 2000). School problems involve academic failure, low attendance, dropping out and changing schools frequently. Poor attachment to school and family comprise strong indicators of future violence (Day, 2008). Peer-relations refer to gang involvement and delinquent peers. Violent and poor communities where drugs are obtainable also compose risk factors for criminal behaviour. The more risk factors a young person is exposed to at

ages 10, 14 and 16 years, the greater the risk is for engaging in violent behaviour at 18 years (Herrenkohl *et al.,* 2000).

Protective factors to violence could predict less involvement in offending behaviour and more positive outcomes. The idea behind reinforcement of protective factors is to build resilience and to model prosocial behaviour amongst high-risk youth (Hall *et al.,* 2012). One study revealed that family dynamics is the most important factor when examining violence in late adolescence (Kim *et al.,* 2016). The same study highlighted the role of school rewarding and attachment in reducing violence. Personality features such as self-esteem and creativity act as protective factors (Day, 2008). However, little evidence exists on interventions and/or programmes reinforcing protective factors in secure settings with young offenders.

3.6.1 Trauma, psychopathology and crime

The existing literature clearly illustrates that experiences of trauma in early childhood might account for violent and offending behaviour later in life (Wright and Liddle, 2014). Trauma in the form of abuse is also linked to victimisation and mental health difficulties. Trauma can impact school and social performance. Chronic trauma impacts and disrupts the regular process of psycho-emotional and brain development and those young people who have been exposed to interpersonal trauma are more likely to be repetitively traumatised. In particular, those young people who have experienced chronic and more serious forms of abuse tend to be involved in more serious offending (Day, 208). Young people in contact with the youth justice system are more prone to neurocognitive deficits that pose them in higher risk whilst being detained (Wright and Liddle, 2014).

Female young offenders are more likely to experience abuse and, particularly sexual abuse (Wright and Liddle, 2014). Research shows that girls are five times more likely to be involved in offending if they have been sexually abused (Day, 2008). Yet, secure settings tend to overlook trauma among females and current policy and practice re-traumatises this group.

Research findings show that 33% to 92% of young people in secure establishments have been maltreated (Day, 2008). Whilst Looked After Children (LAC) comprise 1% of the population, research findings show that they make about 50% of the youth custody's population (Wright and Liddle, 2014). Reports from Her Majesty's Inspectorate of Prisons for England and Wales (HMIP) have revealed that the care of LAC is not clear, poor multiagency collaboration, poor follow-up outcomes. The report released by the HM Chief Inspector of Prisons for England and Wales, 2012 highlighted:

"It remains unacceptable that children who are so at risk that they need to be taken into the state's care also remain low among our national priorities."

3.7 Adolescence as a developmental stage

The emergence of mental disorder symptoms is likely to present during childhood and adolescent years and the increasing rates have caused a major concern for clinicians (Burns *et al.,* 1999). However, it is quite difficult to define the age of onset for mental disorders and most studies adopt a retrospective design and long-term prospective incidence studies are scarce in the field of psychiatric epidemiology (Kessler *et al.,* 2007). Kessler and colleagues (2007) also underscore the importance of mental disorder age onset, as it would help to understand lifetime prevalence and lifetime risk and to prevent the escalation of major mental disorders alongside their secondary symptoms. Certain factors such as age, discontinuity, comorbidity and demographics play a significant role to the developmental stages of mental disorders among youth (Grisso *et al.,* 2005). Developmental psychopathology is not steady and is affected by biological, psychological, cognitive and social context. Peers during different life stages can serve as a reference/comparison point to normal development (Grisso, 2004).

A large prevalence study conducted in the UK including children and adolescents showed that adolescent males between 11 and 16 years are

more likely to be diagnosed with a mental health disorder (Green *et al.,* 2005). Nearly 13% boys and 10% girls in the general community presented with a mental disorder. Disruptive behaviour disorders, such as conduct disorder was the most prevalent mental disorder among this age group followed by emotional disorders including anxiety and depression. Emotional disorders manifested more in females than among males. Remarkably about 60% females presented with generalized anxiety disorder.

Diagnosing mental illness in young individuals is a particularly complex process. Adolescence is a developmental stage characterised by rapid and continuous transformations in the cognitive, emotional, social and physical domains (Kenny *et al.,* 2007; Singh, 2009). Accordingly, the presence of certain symptoms might disappear in the course of time and a past diagnosis of a certain disorder might not fit anymore. Yet this depends on how adolescence is perceived whether it is considered a developmental stage characterised by cognitive, emotional, and physical changes or just an age (Casswell *et al.,* 2012). In this research study, adolescence is defined as a developmental stage underlined by an increasing risk for comorbidity of mental health problems (Lader *et al.,* 2003). Some clinicians perceive adolescence as a developmental stage, and therefore are hesitant in diagnosing personality disorders (PDs) (Guilé and Greenfield, 2004).

3.8 Higher Rates of Mental Disorders among Young Offenders

Research shows that young offenders mostly aged between 16 to 20 years are in greater need of mental health services than the general population as research findings show a higher incidence of mental health problems in this group (Casswell *et al.,* 2012). Prevalence of mental disorders in the general youth population ranges between 14% and 20% (Robertson *et al.,* 2004) whereas in youth offenders varies between 50 to 70% (Burke *et al.,* 2015).

3.8.1 Affective and Anxiety Disorders

Mood and anxiety disorders first manifest during adolescence; the onset of

phobias and impulse-control disorders will emerge before any others (Kessler *et al.,* 2007). International research across several western and non-western countries has shown that the onset of phobias and separation anxiety disorder (SAD) ranges between 7 and 14 years and mood disorders are not very common during early adolescence (Kessler *et al.,* 2007). In particular, SAD is quite prevalent amongst young offenders. One study revealed that 40% of young participants between 12 and 18 years met the criteria for SAD (Robertson *et al.,* 2004). SAD is reported as a frequent disorder among detained youth taken into consideration that this group has been separated from their families at an early stage of their lives (Abram *et al.,* 2008).

A review study found that female young offenders are more susceptible to internalising disorders (Cauffman, 2004). Depression, anxiety, and somatic complaints were higher in females (Caufmann, 2004) in line with research findings highlighting the higher PTSD and depression prevalence rates among females (Sneider *et al.,* 2005). Specifically, 54% of girls reported depression and anxiety symptoms and 59% somatic disturbances compared to 36% of boys presenting depression and anxiety symptoms and 43% somatic disturbances. In one meta-regression study 11% of males and 29% of females were identified to have a major depressive disorder (Fazel *et al.,* 2008). However, depression is difficult to identify in young people and it becomes salient when a young person is involved in delinquent behaviour or has been victim of bullying (Wright and Liddle, 2014).

3.8.1.1 The link between affective disorders and aggression

According to Grisso (2008) childhood and adolescent depression are highlighted by “irritable mood” that can potentially lead to aggressive behaviour towards the self and/or others. Depression among youth manifests as “mood reactive” and, therefore is often accompanied by antisocial behaviour (Biederman and Spencer, 1999). Depressed youth have been found to present high levels of aggression with no significant gender differences (Knox *et al.,* 2000). A possible explanation for

aggressive behaviour amongst depressed adolescence is experiencing violence at early life stages. Further, negative emotions can cause frustrated behaviour inducing violence (Knox *et al.,* 2000).

A longitudinal study following a birth cohort until 21 years showed the association between early onset of anxiety disorders and later on mental health problems including adolescents between 14 and 16 years; the participants were diagnosed with generalized anxiety disorder, overanxious disorder, simple phobia, social phobia and agoraphobia-panic disorder (Woodward and Fergusson, 2001). These findings are in line with previous studies that have underscored the relationship between anxiety disorders in adolescence and risk of anxiety and depression in early adulthood (Pine *et al.,* 1998).

3.8.2 Suicidal behaviour and self-harm

Self-harm and suicidal intent are quite high among young offenders. Several studies have addressed the issue of self-harming in this group. Research findings have shown that self-harming alleviates emotional distress both for offender samples and community populations (Dixon-Gordon *et al.,* 2012). According to Jacobson (2010), 11% of children in UK prisons had attempted suicide and 20% self-harming. US national data report that young offenders in custody have two to four times higher likelihood of committing suicide than the general youth (Abram *et al.,* 2008). Young offenders might present higher rates of suicidal behaviour than the general population since they encounter more risk factors that trigger self-destructive responses such as confinement, distance from family, mental disorder and solitary confinement (Abram *et al.,* 2008). The Youth Justice Board (2005) reports that 27% of young offenders are involved in self-harming behaviours. Young offenders in custodial settings in England and Wales aged 15 to 20 years are more prone to self-harming behaviour than other age groups and 21% of them are involved in self-harming behaviours (Ministry of Justice, 2012). Also, young males aged 15 to 17 in custody are at 18 times higher risk of committing suicide than those in the community (Bradley, 2009). Another briefing estimates that males

are in 8 times higher risk than the general population of committing suicide once they return to the community and females in 36 times higher risk (Sainsbury Centre, 2009).

Wasserman et al (2010) examined past-month suicidal attempts and lifetime suicidal attempts across samples in different settings and they found that youths in detention reported the highest rates of past-month suicidal attempts (3.7%) and for lifetime suicide attempts (17.7%), following those in post-adjudication for past-moth suicide attempts (2.5%) and lifetime suicide attempts (16.3%), and youths entering the justice system had the lowest rates with past-month suicide attempts (1.9%) and lifetime suicide attempts (10.8%). That means that youth in detention are at a higher risk of attempting suicide than those in system intake or post-adjudication. Considering that youths in the system intake might enter the youth justice system for the first time and detainees might have an offence history; a link might exist between offence and suicidal attempts history. The results showed that being a repeated offender increases the likelihood of past-month and lifetime suicide attempts (Wasserman *et al.,* 2010).

3.8.2.1 The link between suicidality and aggression

There is no available research on the association between violent behaviour and suicidal attempts or self-harming behaviour. It is well established that young offenders are in higher risk of engaging in self-harm or attempting to take their own lives and how certain risk factors such as victimization, sexual and physical abuse, bullying, personality traits (e.g. neuroticism and novelty-thrill seeking, low self-esteem), dysfunctional family backgrounds, gender, low socioeconomic status, poor communities, parental substance and alcohol abuse, loss of loved ones, stressful life events, and mental health problems (e.g. depression, anxiety, psychosis) increase suicidal risk (Fergusson *et al.,* 2000). However, it remains unknown whether there is a link between violent behaviour amongst adolescents and suicidal symptomatology.

3.8.3 Psychotic Disorders

Adolescents in custody are in 10 times higher risk for developing psychosis than the general population (Penner *et al.,* 2011). However, psychotic illness is not so common in early adolescence and, consequently in the youth justice system (Grisso, 2008). Psychotic disorder appears between 15 and 17 years and schizophrenia between 15 and 35 years (Kessler *et al.,* 2007). One study found that 5% of young offenders in custody and community presented with psychotic symptoms (Harrington *et al.,* 2005) that is consistent with other research in non-western contexts delineating the prevalence of psychotic disorders amongst young offenders (Ajiboye *et al.,* 2009). Another large study in the UK that included 200 young offenders aged between 18 to 25 years, reported that 15% suffered from psychotic illness (COCOA, 2012). Teplin et al., (2006) found that 0.3% of males and 1.8% of females presented with psychotic disorders. These results are consistent with those of a review on psychotic illness prevalence among juvenile offenders where about 3% youth presented with psychotic disorder (Fazel *et al.,* 2008). Yet, it should be taken into consideration that psychotic symptoms during childhood are not unlikely and do not usually signify psychopathology. Kelleher et al (2012) underscore that adolescents with psychotic symptoms are more likely to have a comorbid psychiatric disorder (Axis I) such as depression or anxiety. Another study has found that adolescents with auditory hallucinations were more prone to developing psychosis in adulthood but not all psychotic-like experiences would unfold to psychosis (Welham *et al.,* 2009).

3.8.3.1 The link between psychotic disorder and aggression

There is lack of evidence linking psychotic disorder with violent behaviour and confirming that young individuals with schizophrenia, for example, are more prone to violence (Grisso *et al.,* 2005). Yet, it should be mentioned that those young offenders committing more violent crimes might present with psychotic symptoms interfering with the nature of the offence (Grisso, 2008). Untreated schizophrenia has been associated with violent behaviour among young adults (Arseneault *et al.,* 2002). Distorted perceptions of a constantly “threatening world” seem to explain aggressive behaviour

amongst schizophrenia patients (Arseneault *et al.,* 2002). Overall, research has concluded that psychosis can increase the likelihood of becoming violent (Douglas *et al.,* 2009). However, Douglas and colleagues (2009) underscored that the risk depends heavily on the comparison group whether individuals with psychotic disorder are compared with people without psychosis or with individuals diagnosed with externalising disorders.

Patients with psychosis are more likely to offend than those without this diagnosis but are less likely to offend when compared with patients presenting with externalising disorders.

3.8.4 Personality Disorders

There is no consensus among clinicians that emerging personality disorders manifesting before the age of 18 will carry on in adulthood (Paris, 2013). Certain personality traits might persist into adulthood though and satisfy the criteria for personality disorders. For example, research provides strong evidence that borderline features turn into borderline personality disorder (Hill *et al.,* 2014). Unfortunately, clinicians tend to misdiagnose borderline symptomatology as mood disorders and particularly bipolar disorder impeding proper treatment (Paris, 2013). Recent research purports that BPD can be diagnosed in adolescence and symptoms are persistent until adulthood (Chanen and McCutcheon, 2013). Winsper and colleagues (2016) conducted a meta-analysis that looked at the aetiological factors of adolescent BPD such as physical, sexual and verbal abuse, dysfunctional family background and found that these factors coincide with adult BPD. Another important finding from this review was the comorbidity between BPD and PTSD in young populations.

Early detection of BPD clinical symptoms might prevent the development of the disorder and interventions should be adjusted according to the stage of the disorder; diagnosis is not the key answer to help alleviate BPD symptoms (Chanen and McCutcheon, 2013). In a criminal justice context, it is suggested that personality disorder interventions would be more efficient

in a detention setting than in the community whereas young people with personality disorders might not be seeking professional help (Kaszynski *et al.,* 2014).

Male young offenders tend to be diagnosed with antisocial personality disorder (ASPD) more often than females (Lader *et al.,* 2003). Lader et al (2000) found that 76% of male remand offenders and 81% of male sentenced young offenders were diagnosed with antisocial personality disorder. In addition, paranoid personality disorder was the second most diagnosed personality disorder, as the results showed 26% of males on remand and 22% of sentenced offenders met the criteria for this disorder. Another study including young participants in a correctional facility between 12 to 22 years, found that about 92% presented with personality disorder symptoms (Kaszynski *et al.,* 2014). An interesting finding from this study was that conduct disorder does not always precede ASPD and the one can manifest without the existence of the other, which attaches more validity to the diagnosis of personality disorders in adolescent populations.

3.8.4.1 The link between personality disorders and aggression

Evidence shows that personality disorders during adolescence are linked to criminal behaviour and early identification might lead to prevention of violent acts (Johnson *et al.,* 2014). For instance, antisocial personality disorder should not be diagnosed unless the individual is over 18 years, as stated in DSM-IV and DSM-V. However, antisocial traits in adolescence manifested in conduct disorder have been perceived as prodromal signs of antisocial personality disorder (ASPD) later in adulthood and also conduct disorder provides a criterion for ASPD diagnosis in adulthood (Loeber *et al.,* 2002). It is well established that criminal behaviour and age are correlated and offending declines by age whilst a great number of offenders are adolescents (Moffitt, 1993). Conduct disorder during adolescence seems to predict violent behaviour later in the developmental trajectory alongside ASPD. Only a small number manifest antisocial traits as children that progress into criminal behaviour in adulthood; yet, most of

those who will be diagnosed with ASPD had antisocial traits as adolescents (Moffitt, 1993).

Young offenders with BPD, ASPD, and NPD are more likely to manifest aggressive and violent behaviour than those with schizoid personality disorder and those with schizotypal personality disorder seem particularly prone to violence (Kaszynski *et al.,* 2014).

Personality disorders in general have been linked to violent behaviour and offenders diagnosed with such disorders are more likely to act violently as individuals with schizophrenia, bipolar disorder and head injury (Yu *et al.,* 2012). Yu and colleagues reported in a meta-analysis that offenders with ASPD have a similar risk of reoffending to those with other personality disorders- yet a higher risk of violence.

3.8.5 Neurodevelopmental Disorders

According to DSM-5 learning disabilities, autism spectrum disorders and attention deficit hyperactivity disorder (ADHD) are classified as neurodevelopmental disorders (Underwood *et al.,* 2013). DSM-5 changed the concept of autism spectrum disorder in terms of consistency, which initiated an ongoing debate on exclusion of people in the spectrum. Studies have shown that DSM-5 is less sensitive than DSM-IV and young people with high IQ can be overlooked as falling in the spectrum. This creates additional problems concerning access to services in case the young people do not fit within the diagnosis (Volkmar and Partland, 2014). Neurodevelopmental disorders begin in early childhood and are persistent across the lifespan and prison settings seem to be unresponsive to this group of individuals' needs (Paterson, 2007).

Autism spectrum disorders (ASD) are also prevalent in young offenders. ASDs include autistic disorder, Asperger's syndrome and atypical autism (Långström *et al.,* 2008). However, there is little evidence in the current literature about ASD prevalence in adolescent offenders and most research carried out includes adult offenders (Griffin and Staniforth in Andrews,

2015). Young people with ASD present with several impairments cognitively and socially that interfere with their executive functioning and planning alongside their performance in social contexts. ASD is seen as a pervasive developmental disorder, which means it continues across the life span. Sadly, ASD is not often recognized in youth justice settings resulting in offending behaviour (Griffin and Staniforth in Andrews, 2015). One report including two case studies on two young detained persons with Asperger syndrome revealed that prison has exacerbated their current symptoms and have become socially marginalized and subjects to bullying behaviour (Paterson, 2007). Both cases presented lack of empathy and insight impacting adversely their daily social interactions.

Research has shown that ADHD and conduct disorders usually occur at the same time and conduct disorders derives from hyperactivity (Retz *et al.,* 2004). Retz's study (2004) is in conjunction with this evidence where young offenders show externalising-conduct problems and aggressiveness.

3.8.5.1 The link between ASD and ADHD and aggression

There is lack of robust evidence linking ASD with criminal behaviour. Yet, one study identified potential risk factors for offending among individuals with ASD including being male, having a comorbid substance abuse and presenting with Asperger's disorder (Långström *et al.,* 2008). The same study purports that this group does not have any different characteristics than the general offending population.

Certain factors can make individuals with ASD more prone to aggressive and offending behaviour: social vulnerability-high in suggestibility, routine interruption, inability to understand social norms and obsessive behaviour (Paterson, 2007).

ADHD has been correlated with criminal and antisocial behaviour and has also become a risk factor for offending and being in contact with the judicial system and offending behaviour might begin before 11 years (Einat and Einat, 2008). In particular, it has been reported that youth with ADHD are up to five times higher risk being involved with the youth justice system. There is a general consensus that detained youth present with higher

ADHD rates than youth in the community and persistence of ADHD symptoms determine contact with the youth justice system (Young in Fitzgerald *et al.,* 2007). One meta-analysis on the relationship between ADHD and delinquent behaviour revealed that ADHD impacts offending behaviour (Pratt *et al.,* 2002). Two explanations were provided for this review's results. The first explanation relies on low-self control theory posing ADHD groups at a higher risk for engaging in criminal behaviour. The second explanation counts on the *child effect* theory where tantrums and maladaptive child behaviour leads to negative parental interventions that exacerbate existing disorderly symptoms.

The nature of crimes committed by ADHD groups tends to be impulsive and driven by novelty seeking urges and are not violent or premeditated offences (Young in Fitzgerald *et al.,* 2007). Lack of impulse control along with substance use compose the main characteristics of ADHD offenders. It has been reported that the comorbidity with conduct disorder triggers offending behaviour in delinquent youth while controversial research purports that ADHD symptoms such as lack of attention and hyperactivity lead to offending (Einat and Einat, 2008).

Young offenders presenting with neurocognitive deficits remain the most vulnerable group in the system taking into account the lack or limited understanding or ability to reflect on their offence. According to the Youth Justice Board report (2014:30) on trauma among young offenders:

"They question whether the current criminal justice system approach is fair in committing young people with neurodisability to custody, when those young people may not be able to understand the consequences of their actions or have the cognitive capacity to instruct solicitors."

3.8.6 Learning Difficulties and Disabilities

Learning disabilities relate to cognitive deficiencies and to low intelligence levels (IQ) and emerge before adulthood (Hughes, 2012). In order to be diagnosed with a learning disability there are certain criteria that need to be

met, such as a negative correlation between performance and achievement and academic failure and/or low performance and also some level of cognitive impairment in terms of information processing (Einat and Einat, 2008).

Learning disabilities among young offenders are quite common, with between 23-32% of young individuals in custody having a generalized learning disability compared to 2-4% in the general population (Hughes, 2012). The prison population presents with similar educational backgrounds such as dropping-out from school, low academic performance, intellectual disabilities, illiteracy and high unemployment (Winters, 1997). A large study including 301 young offenders from the secure estate and the community reported that a large percentage, about a quarter, had learning disabilities that were identified with IQ scores below 70 and a third had borderline scores varying between 70 and 80 (Harrington *et al.,* 2005). Learning difficulties include literacy difficulties such as dyslexia, dyspraxia, and dyscalculia (Hughes, 2012). Dyslexia appears in 43% to 57% of young offenders. Educational needs among this group are relatively high that is associated with being out of school for quite long periods of time (Cresswell *et al.,* 2012;). A large proportion, about 89% of young people, in Young Offender Institutions (YOIs), have a history of school exclusion, which also increases the likelihood of offending by the age of 21 (Berelowitz, 2011). This group encounters literacy problems presenting low reading levels compared to the general population. It appears that there might be a relationship between school exclusion and learning difficulties (Ford *et al.,* 2008). Herrington (2009) found that young offenders with borderline intelligence present with two characteristics: temporary housing and writing and reading difficulties at school. These two factors seemed to precipitate borderline intellectual disability in a group of young inmates accommodated at a YOI. Accordingly, young offenders with borderline intelligence might struggle more whilst in the justice system as they are less cognitively equipped to appraise their current situation. Further, it looks quite problematic that the justice system is not adaptive

and unresponsive to young offenders with borderline disability (Herrington, 2009).

However, young offenders with learning disabilities do not receive adequate support whilst in detention settings. Their needs might be missed if staff are not well trained, and special education services might not be provided (Winters, 1997).

3.8.6.1 The link between learning disabilities and aggression

Learning difficulties have been linked to antisocial behaviour and to ADHD and for some to criminal behaviour (Penner *et al.,* 2011). As a result, being socially marginalized and expelled from school due to disruptive behaviour could escalate to more serious delinquent behaviour. The inadequacy of the school system to support young people with learning disabilities reinforces offending behaviour at a very early life stage (Einat and Einat, 2008). Ostensibly, past research has not established the association between offending and learning disabilities but low intelligence composes a risk factor for criminal behaviour (Herrington, 2009). Learning disabilities are deemed as risk factor to offending (Winters, 1997). Self-esteem and school performance seem to be interconnected and also can affect adversely the emotional well-being of young people (Winters, 1997). Accordingly, it is not surprising that youth who fail academically might feel marginalized and stigmatized in the school arena and therefore, they seek acceptance by joining delinquent peers and leaving school (Einat and Einat, 2008). Youth, who had been at school for less than 10 years, are more prone to antisocial behaviour and also to engage in offending (Einat and Einat, 2008).

3.8.7 Substance Abuse Problems

Adolescent offenders present with higher rates of substance use than general youth and they are in almost three times higher risk of using a drug (Chassin, 2008). About 25% to 65% of detained adolescents across various settings have a substance use disorder (Chassin, 2008). However, substance use and substance use disorders differ and the latter category

implies a more persistent behaviour pattern that is linked to poor cognitive and social performance. Offenders with substance abuse problems tend to present co-occurring mental health problems. Female young offenders have a higher likelihood of substance abuse disorder and comorbidity than male young offenders (Chassin, 2008). Chassin (2008) reports that youth with comorbid mental disorders are more difficult to treat taking into consideration that they have more severe substance abuse problems along with poor family environments. Substance abuse is also linked to antisocial personality disorder and more severe criminal behaviour (McClelland *et al., 2004*).

Kenny and colleagues (2007) used 800 young offenders on community orders in South New Wales to examine prevalence of mental health disorders. Findings from this study reveal that 26% of the sample presented severe symptoms of substance abuse disorders. Robertson and colleagues (2004) found that 28% female and 40% male juvenile offenders presented with substance abuse problems and overall prevalence was 36%. The authors also reported that most of the participants had used alcohol and marijuana. Interestingly, female young offenders tended to use cocaine more frequently than their male counterparts (McClelland *et al.,* 2004). Research has shown that most of the youth in detention settings have used substances at least once and about 90% have used drugs the last six months (McClelland *et al.,* 2004).

3.8.7.1 The link between substance abuse and aggressive behaviour

The extant literature has established a strong link between substance abuse including drugs and alcohol and offending behaviour (Chassin, 2008). Dawkins (1997) found that young offenders involved in violent and non-violent crimes had previously used substances. However, the author noticed that the pattern of offending varies between alcohol and marijuana users. Young people who were engaged in severe fights had previously consumed alcohol while those involved in theft crimes had smoked marijuana.

Young offenders with substance use problems tend to reoffend and to follow a more criminal persistent trajectory (McClelland *et al.,* 2004). Substance use increases dramatically the likelihood of continuous offending. Ruiz et al., (2012), found that recidivism and substance relapse are associated to substance addiction and offenders who have a substance history have a higher likelihood of being engaged in oppositional behaviours (Chandler *et al.,* 2009).

3.8.8 Disruptive Behaviour Disorders

Disruptive behaviour disorders such as conduct disorder (CD) and oppositional defiant disorder (ODD) tend to be persistent across the lifespan in line with research evidence underscoring that younger detainees have higher rates of disruptive behaviour disorders (Karnik *et al.,* 2010). Antisocial behaviour is manifested in the form of conduct disorder in children and adolescents and is characterised by the following symptoms: aggressive behaviour towards others or animals, property vandalism and fire setting, theft and breach of social norms and rules (Kazdin, 1995). There are certain risk factors that might trigger the onset of conduct disorder such as hyperactivity, poor academic performance and lack of problem-solving skills (Kazdin, 1995). It is not uncommon that youth with CD have neglectful parents with psychopathology. ODD includes antisocial symptoms as well and concurs with CD (Kazdin,1995). However, it has been reported in the literature that patients with ODD will initiate help-seeking behaviour while those with CD will be resistant to engage in mental health services (Burke *et al.,* 2015). The onset of ODD is around 7 to 15 years and of conduct disorder between 9 and 14 years (Kessler *et al.,* 2007). CD is in its peak during 12 and 16 years (Kazdin,1995). Grisso (2004) delineates CD and highlights that CD usually occurs with other mental disorders and, therefore attains clinical significance; otherwise it should be clinically examined whether it constitutes a mental disorder. CD is underlined by violating the law and social norms that does not signify psychopathology and clinical cause on its own.

Research has revealed that CD is about 10 times higher in juvenile justice populations than in community youth (Burke *et al.,* 2015). Karnik et al (2010) reported that 97% of girls 16 years and younger and 87% of those 17 years and older have a conduct disorder. For boys the prevalence rate was 94% in both age groups. ODD was evident in 29% of males who were 16 and younger and 22% who were 17 years and younger. Girls had slighter higher rates with 42% of females who were16 years and younger and 20% of them who were 17 years and older having ODD.

3.8.8.1 The link between disruptive behaviour disorders and violent behaviour

Many studies have linked conduct disorder with offending behaviour, as it is one of the most common diagnosed mental disorders among young offenders (Burke *et al.,* 2015). Conduct problems present in childhood years at home and school settings and, although, there is a strong link with future conduct disorder, conduct problems do not necessarily constitute a mental disorder (Babinski *et al.,* 1999). Conduct problems have been pathologised across the literature and, thereby, we have to be cautious when attaching the label of conduct disorder among youth (Kurtz *et al.,* 1998). Conduct disorder constitutes one of the most common disorders across juvenile settings and has been resistant to treatment (Burns *et al.,* 1999). However, the presence of antisocial features during adolescence might be part of the young person's developmental trajectory and might not persist into adulthood whilst empathy and remorselessness imply future violent and criminal behaviour (Grisso *et al.,* 2005). One study included a sample of youth offenders between 14 and 18 years and examined the onset of antisocial behaviour, first arrest, and court referral (DeLisi *et al.,* 2013). The findings revealed that youth with CD had been involved in rules violation (mean age 12 years), arrest and court (mean age 12 years) procedures (mean age 14 years) much earlier than other groups without CD. Notably, young offenders with CD were in contact with the youth justice system as early as at six or seven years. This fact might explain future involvement into the offending cycle, as early onset of criminal behaviour is associated to institutionalization.

3.9 Conclusions

This chapter was a critical literature review of the area of mental disorders in young offenders and examined the association between violent behaviour and offending and poor mental health. The link between crime and psychopathology has been discussed multiple times in the current literature and young people with specific mental health problems are more likely to act violently (Grisso, 2004). However, the most recent review was conducted a decade ago and has not captured a wide range of mental health problems and difficulties that are considered risk factors to violent behaviour such as emerging personality disorders and self-harm (Fazel *et al.,* 2008). There is no up to date systematic review, which is why the first phase of this research study will aim to synthesise quantitatively the prevalence of a wide range of mental disorders and symptoms in young offenders. The systematic review and meta-analysis will answer the following research question: 'What are the demographic characteristics and prevalence of mental health disorders in young offenders in detention?'

Young people in forensic settings present with increasingly high complex needs including emerging personality disorder traits and learning disabilities. Those young people with neurodevelopmental needs and persistent emerging personality disorder traits comprise the most vulnerable group with comorbid mental health disorders. Self-harming is a common and concerning symptom amongst young female offenders in detention, according to previous studies (Lader *et al.,* 2000). Yet, the current literature has not combined different studies measuring self-harming and learning disabilities in high-risk populations. Young people transitioning to forensic child and adolescent mental health services are referred from prison settings and might belong to this vulnerable group with complex presentations. One of the eligibility criteria to be detained under the Mental Health Act and to be admitted to inpatient FCAMHS is to present harm to self. Therefore, understanding this group's needs before and during transition by studying the prevalence of mental disorders whilst in detention and looking at the prevalence of mental health disorders in

forensic inpatient services may help to manage symptom escalation and risk presentation. This thesis will address the clinical characteristics of young people accommodated in forensic settings with the use of a mapping exercise and a case note review to answer the following research question: 'What are the demographic characteristics and prevalence of mental health disorders in young offenders?' The mapping exercise, which is the second phase of this study, will address the following research question based on the identified literature gaps in Chapter 2: 'What are the transition, policies, processes and practices of FCAMHS for young offenders in secure adolescent units in England?' The case note review, which is the third phase of this study, will explore the following research question: 'What are the annual transition rates and pathways from FCAMHS?' The interviews, which comprise the fourth phase of this study, will address the following question: ' What are the views and experiences of young offenders, their carers and healthcare professionals concerning the transition process?' The next chapter presents the methodology and methods used in this research study and elaborates on the four different phases.

4 Methodology and Methods

4.1 Chapter overview

This chapter outlines the underpinning methodology used in this thesis. First, I explain the reasons for choosing a mixed-methods design and then I outline the different phases involved in this research study. Each phase of this study is described into detail by providing the aims, data collection methods, sample description and data analysis.

This is a sequential exploratory mixed methods study with four interlinked phases, which aim to address the following research questions that have emerged from a critical review of the literature of the field. There is a research question for each study phase, using a different research method.

4.2 Research Questions:

1. What have been the demographic characteristics and prevalence of mental health disorders in detained young offenders?
    (a) A systematic review and meta-analysis on mental health disorders in young offenders;
2. What are the transition policies, processes and practices of FCAMHS for young offenders in secure adolescent units in England?
    (b) A mapping exercise to identify policy, transition preparation processes and outcomes across six medium secure adolescent units in England and also to identify young offenders approaching the transition age boundary within a six-month time frame;
3. What are the annual transition rates and pathways from FCAMHS?
    (c) Retrospective case note review looking at discharged patients from FCAMHS during the preceding year (2015-2016);
4. What are the views and experiences of young offenders, their carers and healthcare providers concerning the transition process?

(d) Semi-structured interviews to explore the views of FCAMHS healthcare providers, adult healthcare professionals, and service users and their parents and carers about their experiences of the transition process across services.

4.3 Research Design

Mixed methods research is a popular design in health sciences and it facilitates the evaluation and effectiveness of healthcare provision (O'Cathain, 2009). This approach is acknowledged in health care research as impacting health policy and improving patients' life quality and outcomes (Graff, 2016). The interdisciplinary character of health sciences necessitates the use of mixed methods considering the different approaches adopted by each field. Health sciences include medical research, social sciences such as psychology, nursing and public health. Quantitative methods and, specifically, randomised control trials have been used traditionally in health science research whilst qualitative methods have been introduced more recently. Quantitative methodology facilitated the testing of interventions but did not address why certain interventions worked and others led to poorer outcomes (O'Cathain, 2009). Therefore, the combination of both quantitative and qualitative methods was embraced in health research to answer and study more complex questions and links.

4.3.1 Mixed Methods Design

A mixed methods design enhances the validity and interpretation of the results (O'Cathain *et al.,* 2007). A single qualitative or quantitative study would not provide substantial answers for transition of care in young offenders due to the complexities involved in this population. Quantitative methods can provide broader knowledge about the procedural and organisational components while qualitative are used to explore the individual perspectives and experiences. Quantitative measures can inform on the general context and qualitative methods can enhance in-depth rich knowledge. Traditionally, quantitative and qualitative methods have been

described as *antithetical* and, therefore, the use of qualitative methods has been seen as complimentary enriching quantitative data (Pope and Mays, 1995). Mixed methods research acknowledges the strengths of both methods and each method compensates for the weaknesses of the other. The advantage of using mixed methods designs is the robustness of the findings' interpretation. Researchers can expand on the findings and learn more from their data sets (O'Cathain *et al.,* 2010). Quantitative data help to define and scope out the problem of the research question and qualitative data offer in-depth exploration of the refined research question (Ivankova *et al.*, 2006). Mixed methods studies can use surveys and questionnaires by adopting quantitative methods and interviews or focus groups or case studies to reflect on the participants' experiences and views. Quantitative and qualitative data are collected and analysed separately during a mixed methods design and then both sets of data are discussed and/or interpreted together in a process called triangulation (O'Cathain *et al.,* 2010). The process of integration is essential according to most mixed methods methodologists. Methodological triangulation used in this research study pertains to different research methods and data collection techniques and data triangulation refers to different sets of data that increased the robustness and validity of the findings (Farmer *et al.,* 2006).

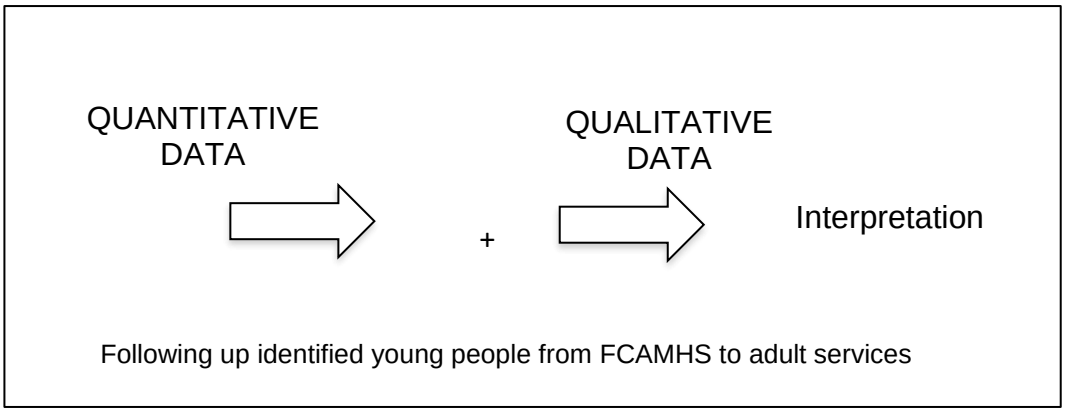
This research study uses mixed methods for an analysis of the area of transition of care from forensic child and adolescent mental health services among young offenders using mixed methods to examine transition of care from forensic child and adolescent mental health services (FCAMHS) in all nationally commissioned medium secure units, for young offenders with mental health problems.

4.3.1.1 Research Questions

The sequential exploratory design was used to facilitate chronological data collection and findings interpretation in discussion and conclusion sections of this thesis (Creswell, 2013). The sequential approach enhanced the overall methodology, as a prospective design was adopted. In terms of weighting of

the data, quantitative and qualitative results were equally important. The quantitative results built the foundations to explore more in-depth the young people's transition experiences. There were four phases included in this research study. The first phase was a systematic literature review and meta-analysis to examine the prevalence of mental health disorders in young offenders. The second phase, which was a mapping exercise, was essential to identify potential participants and was used as a form of survey to calculate annual transition rates and number of open cases in order to assess the number of eligible young people for transition to adult services. I implemented the mapping exercise and then I followed up young people once they moved to adult mental health services and community settings to conduct interviews. The mapping exercise and the third phase of the study, which included the case note reviews, helped to scope the magnitude of the problem numerically and the interviews to explore the reasons underlying these numbers. The fourth phase of the study included qualitative interviews, which were used to understand the participants' views and experiences and to reflect on healthcare professionals' perspectives and understandings of policy and outcomes.

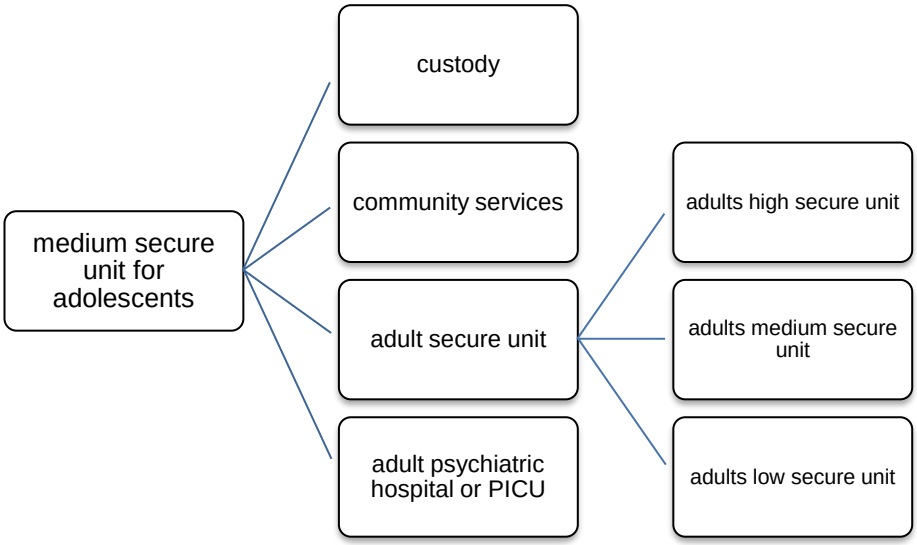
Figure 2. Exploratory Sequential Model (Clarke and Creswell, 2008)



There are several transitions that this population undergoes but for the purposes of this study, I examined young people's pathways from forensic

adolescent medium secure hospitals including all national services to adult services along different transition pathways including: forensic adolescent secure units to forensic adult services and psychiatric hospitals, to the community (home) or community placements including supported accommodation and residential settings, and to custody.

Figure 3. Discharge destinations from medium secure adolescent units



4.4 Study summaries and descriptions

Figure 4. Diagram of the study and different phases

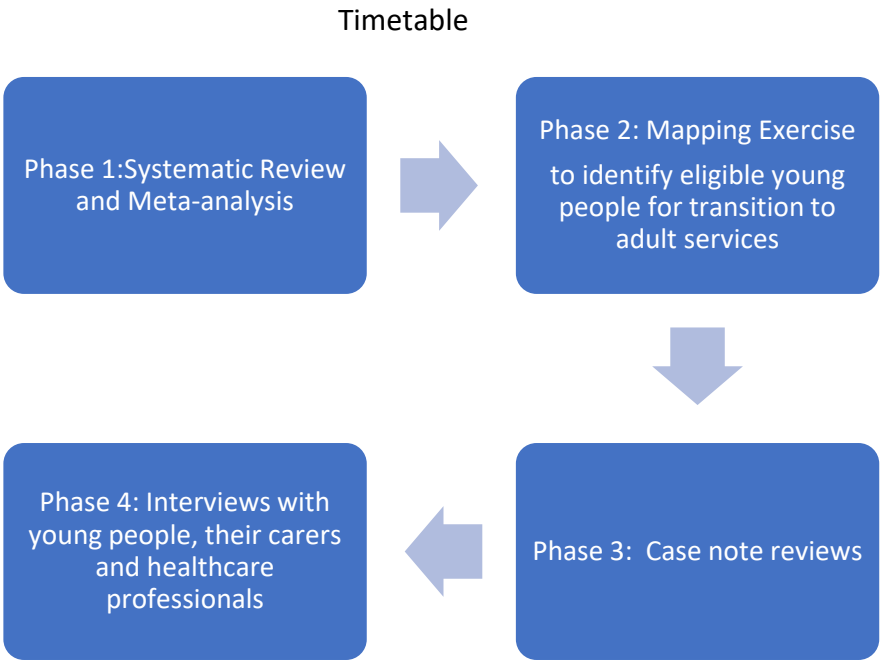


Table 2. Data set and account of analysis

Phases	Procedure	Sample	Product
1)Quantitative data analysis	Systematic review	N= 30 studies	• Meta-analysis • Meta-regression • Sensitivity-analysis
2)Quantitative data collection	Mapping exercise	N= 34 young people	Descriptive analysis
3)Qualitative data collection	Mapping exercise	N= 6 Local Collaborators	• Content analysis • Thematic analysis
4)Qualitative data collection	Case note review	N= 32 cases	Documentary analysis
	Interviews with young people	N= 13	Thematic analysis
	Interviews with FCAMHS professionals	N= 21	Thematic analysis
	Interviews with AMHS professionals	N= 13	Thematic analysis
	Interviews with families	N= 5	Thematic analysis

4.4.1 Phase 1- Mental health problems in adolescent offenders: A systematic review and meta-analysis

Phase 1 addressed this research question: What have been the demographic characteristics and prevalence of mental health disorders in young offenders in transition?

4.4.1.1 The aims of phase 1 were:

This systematic review and meta-analysis aimed:

- to identify the prevalence of mental health disorders among young people in detention;

to unravel relationships between variables that were previously overlooked (Littell *et al.,* 2008);

- to address gender, sample size, age and setting differences in prevalence rates among young offenders;
- to include a broader spectrum of mental health problems (emerging personality disorders) along with learning disabilities, suicidal behaviour and self-harming than previous reviews (Colins *et al.,* 2010; Fazel *et al.* 2008).

4.4.1.2 Literature Search Strategy

Searches included the following databases: Web of Science, MEDLINE, Embase, and PsycINFO. References from the retrieved studies were also examined to find related studies. The MOOSE (Stroup *et al.,* 2000) guidelines for Meta-Analysis of Observational Studies in Epidemiology guide this systematic review. Additionally, the literature was scrutinised to identify similar studies using meta-analytic methods on prevalence of mental disorders (Fazel *et al.,* 2008). The authors of the primary studies were contacted to ask for missing or unclear data. The results of the search are displayed in the form of the PRISMA flow diagram.

4.4.1.3 Data collection

For the purposes of the meta-analysis the PRISMA-P protocol was followed so the reviewers adhere to the initial inclusion criteria and apply them systematically (Denison *et al.,* 2013). Also, the protocol helped to reduce any potential bias (Littell *et al.,* 2008). Another purpose of the protocol development was to avoid selective reporting (Shamseer *et al.,* 2015).

4.4.1.4 Description of studies and methodology

For the purposes of the meta-analysis, expert statistical advice was sought from the Statistics Clinic at Warwick Medical School (Dr Peter Kimani). A descriptive study was carried out to summarise the results of the studies included in the review. The key characteristics of each study were summarised comprehensively including authors, population, diagnostic

tool, interviewer, diagnoses, settings, interviewer, geographic location and studies' weaknesses. Forest plots display the assigned weight of each study along with 95% confidence intervals and sample size. Subgroup analysis was conducted (if more than 10 studies were included for each mental health problem) to look for group differences, such as prevalence of mental disorders between males and females, among different ethnic groups, and among different ages. This analysis helped to detect variability in effect sizes (Field and Gillett, 2010). Random effects model was mainly applied as the effect sizes of the intended population varied (Field and Gillett, 2010). In addition, the random effects model allowed for further generalizations in the population and that served the purposes of this study (Hunter and Schmidt, 2000; Field and Gillett, 2010). The Hunter and Schmidt (2004) method was adopted.

4.4.2 Phase 2- Mapping transitional care-pathways among young people discharged from forensic child and adolescent mental health services

Phase 2 addressed this research question: What are the transition policies, processes and practices of FCAMHS for young offenders in secure adolescent units in England?

4.4.2.1 The aims of Phase 2 were:

- to identify the transition policies and processes including preparation, planning and management in FCAMHS across England;
- to conduct a mapping exercise tracking the numbers of actual referrals within a six-month period;
- to look at discharge destinations across different mental health hospitals involved in the transition process at a national level;
- to compare policy and practice across different mental health trusts;
- to examine the characteristics of young people accommodated at FCAMHS;

- to examine whether the age transition boundaries differ from FCAMH to FCAMH;
- to identify the young people referred to adult mental health services.

4.4.2.2 Data collection

A predefined mapping exercise was performed to identify the number of young people moving to adult services and the community. This group of young people had either reached or were about to reach the age transition boundary. This study looked at young people who would reach or had reached 18 years to be discharged from forensic child and adolescent mental health services to adult services, community, and custody between May 2016 to November 2016. The cut-off threshold for including participants in the study was age. I included young people 17.5 years and above by 30th November 2016. The mapping exercise was in paper-format and was collected either in person or electronically via email. The aim of mapping was to identify numbers of transition from adolescent forensic secure mental health units to adult forensic secure units, to community, to adult psychiatric hospitals and to custody. In this phase 2 of the research study, the TRACK mapping exercise was used to collect information about structure and organisation and also transition protocols and annual numbers for individuals in transition (Singh *et al.,* 2010). The mapping questionnaire was slightly modified, as the TRACK version applied to non-forensic CAMHS. The TRACK mapping tool was used due to the lack of validated standardised tools in the field of transitions. Therefore, the most relevant tool was the mapping exercise after certain amendments and adjustments to be relevant to forensic populations. There is a lack of validated tools measuring transition outcomes and policies in forensic inpatient needs other than Secure Honosca that measures clinical outcomes and is mostly used for the purpose clinical audits in the UK. A decision had to be made about what was the most suitable tool.. The TRACK study successfully used the mapping exercise to elicit information on outcomes, policies and processes of transitions.

The amendments pertained to an additional table that specifically required diagnosis, legal status, discharge destination, gender, ethnicity and date of birth in order to identify potential participants for post-transition interviews. Six adolescent medium secure hospitals in six geographical locations were included: Birmingham (Ardenleigh), Northampton (Malcolm Arnold House-current Fitzroy House), London (Wells Unit), Newcastle (Alnwood Clinic), Manchester (Gardener Unit) and Southampton (Bluebird House). The mapping exercise also looked at transition policies (existing guidelines in written form) and processes, transition timeline, psychiatric diagnosis, index offence, MHA section status, discharge dates and transition destination. The young people identified by the mapping exercise were interviewed once they moved to adult services (post-transition) and, specifically, within five months of their transition. Clearly, this timeframe depended on coordination between the researcher and the responsible clinicians/local collaborators from FCAMHS and adult services. The participants were recruited consecutively and once the desired number of participants was reached within this time frame, recruitment terminated. However, throughout these months no more eligible participants were identified for recruitment to increase the sample size. The number of young people relied heavily on their consent to participate in the study.

Initially, local collaborators had to be identified for each site; phone calls and emails lasted two to five months (January 2016-June 2016) until I found a clinician willing to collaborate. Local collaborators were contacted usually consultant forensic adolescent psychiatrists about the purpose of the study. Whilst all sites were contacted at the same period, responses were often delayed due to the high workload of clinicians. A reminder email was sent to all hospitals to return the tool. It took three to five months to coordinate with two of the hospitals and identify potential local collaborators. Then, meetings were booked to meet with the local collaborator or principal investigator.

Multiple visits were arranged to each hospital to discuss in further detail the objectives of the study and to administer the mapping exercise after giving

instructions and guidance to the clinicians. The clinicians had to return the form either electronically or during the researcher's next site visit. This process lasted from June 2016 to September 2016. However, some sites did not complete the mapping exercise until March 2017 regarding technical questions; they had to look at site's records to retrieve certain information concerning patients' discharges from previous years. Additionally, clinicians were asked for patients' transition waiting times from referral date to discharge date to adult services. Some patients were not discharged within a six-month period and were still in services after almost a year's time. The patients close to transition to adult services were identified within the six-month period in a consecutive manner. Two clinicians completed the mapping exercise during one of my visits to the sites to ensure they had responded correctly and to address any additional concerns.

The mapping exercise was distributed to clinicians and any queries regarding the tool were clarified either in person, via telephone or email. The clinicians had to return the form either electronically or during the researcher's next site visit through NHS email accounts and as a password protected document to ensure confidentiality. Additionally, clinicians were asked for patients' waiting time from referral to discharge date to adult services and community. Eligible patients were identified between May and November 2016. Some participants were not discharged almost a year beyond their transition time. Respondents were sent reminder and any queries answered. Returns were often delayed because respondents were uncertain about the patient's destination or transition date.

The local collaborators or principal investigators were identified beforehand during the ethics process and were asked whether they were interested in participating in the research study via email contact. Five consultant forensic child and adolescent psychiatrists and one consultant forensic child and adolescent psychologist agreed to take part and collaborate in the study. After receiving ethics approval, the first visit took place at

different times depending on their availability and response time. Each site was visited multiple times to contact health- care professionals and gain access to the necessary data and to address whether they used any for protocols' policies. The purpose of the visits was to plan how the objectives of the study would be achieved (e.g. strategy to approach the other sites, significance of the research) and to explain the aims of the study. Each site required a certain amount of information about the study regarding the process and their role in the study These key workers were asked to complete the mapping exercise to track young offenders who were about to cross the age boundary for transition within the following six months (May 30th 2016- November 30th 2016collethe collection of the mapping exercise and any issues with the questionnaires were addressed on the second visit.

4.4.2.3 Mapping exercise design

This tool was initially designed and successfully used in the TRACK study that examined transitions from general child and adolescent mental health services to adult mental health services (Singh *et al.,* 2010). Taking into consideration the forensic context of the current study some adjustments were made to meet to the needs of this cohort. The amendments were discussed with the two supervisors (SS and VF). The mapping tool was adapted to a forensic population. There were no forensic tools available to measure forensic processes and outcomes.

The modified tool was piloted prior to wider distribution and some questions were adjusted accordingly, following clinician input. Piloting the mapping tool with forensic child and adolescent psychiatrists from national FCAMHS justifies the use of this measure. The questionnaire was piloted at the first participating inpatient unit in the West Midlands-that was the Lead Trust- and some questions were adjusted accordingly with the input of the consultant forensic child and adolescent psychiatrist. One question was completely removed - "Do you have a written closure policy?" None of the forensic services had such a policy and this was corroborated by all

clinicians. Clinical input was essential to establish the effectiveness and appropriateness of the mapping tool considering the lack of validated and uniform applied tools measuring transition processes and outcomes in forensic inpatient settings. All clinicians involved agreed that the written closure policy question should be removed since it did not pertain to national FCAMHS and was more levant for routine CAMHS research. The remaining questions were all pertinent to the forensic context and neither of the clinicians objected their use or encountered difficulties in answering them. The patient list table was slightly updated adding offence, Mental Health Act section. There is currently an effort to develop appropriate measures for forensic inpatient population outcomes and, specifically for upcoming transitions to adult services. At the time of data collection, there were no validated forensic transition measures.

The mapping exercise aimed to compare transition policies and procedures among the six hospitals and to identify commonalities and/or differences. This phase examined what mechanisms are in place during the transition process for the young person regarding transition planning and management. Integration of services and family involvement played a fundamental role to the transition process at this stage.

4.4.2.4 Data analysis

Descriptive statistics were used to estimate the number of young people transitioning within this six-month period, annual transition rates, ethnicity, age at time of referral and age transition boundary, diagnosis, index offence, legal status and discharge destination. Responses from the mapping exercise were analysed with STATA software 14.1 to look for frequencies and percentages of annual rates. Where transitions protocols were identified, content analysis was performed. Qualitative methods were used to explore the open-ended questions in the mapping exercise and were thematically analysed. For the data analysis stage advice from a statistician based at Warwick Medical School was sought in order to ascertain that the used methods were appropriate for the data. Transition rates within this six-

month period were looked at along with demographics such as gender, ethnicity and age at time of referral to adult services and community, staff grade, offence indexes, Mental Health Act Section and receiving services, transition planning and management, and policy discharge guidelines.

Responses from the mapping exercise were analysed with Stata 14 software to look for frequencies and percentages of annual rates. There was one open-ended question that pertained to the discharge process from FACMHS allowed to perform thematic analysis based on similarity and repetitiveness of themes and patterns concerning transition discharge to adult services. The question asked local collaborators to identify the process of discharge followed in their service and to elaborate on how they carry out transitions to adult and community services. All responses were read multiple times searching for relevant themes and then were organised in a table with emerging sub-themes. The question asked local collaborators to elaborate on the transition process. More details can be found on Appendix 7 where the mapping exercise is attached. The two protocols provided by the FCAMHS are not included for confidentiality reasons, as they are not public documents. Therefore, they are described in detail in the results section considering their context and semantics. Content analysis was conducted for the two transition protocols that were available from two services. The two protocols were read multiple times to find patterns and similarities in the discharge process between the two FCAMHS. The themes were analysed deductively, as I was interested in transition guidelines followed by FCAMHS. I was looking for transition procedures from preparation, management, and parallel joint working to follow up. These protocols were analysed qualitatively considering theoretical themes from the transition literature. A coding scheme was developed according to themes that emerged from the literature (Singh *et al.,* 2010) and from the TRACK study such as preparation and management of transitions, handover planning, transition destination and follow up with FCAMHS post-discharge, CPA process, risk assessment and procedures in place when transitions are delayed. Directed content analysis was applied with the above predetermined codes (Hsieh and Shannon, 2005). This type of analysis was

used with codes resulting from previous research findings and codes were categorised accordingly.

4.4.3 Phase 3- Transitional pathways among young people discharged from forensic child and adolescent mental health services: A retrospective national case note audit

Phase 3 addressed this research question: What are the annual transition rates and pathways from FCAMHS?

4.4.3.1 The aims of Phase 3 were:

- to identify the annual transition rates from FCAMHS to adult services for the preceding year 2014 to 2015;
- to look at retrospective cases and identify the characteristics of this group including mental health diagnosis, legal status, educational level, family background, placement before and after discharge;
- to look at age at time of discharge to adult services;
- to identify transitional pathways for all case notes.

4.4.3.2 Data collection

Phase 3 consisted of case note reviews based on annual discharge rates-transitions to adult services across six medium secure adolescent hospitals across England located in Birmingham (Ardenleigh), Northampton (Malcolm Arnold House-current Fitzroy House), Southampton (Bluebird House), Newcastle (Alnwood clinic), London (Wells Unit), and Manchester (Gardener Unit). Patients discharged from June 1st 2015 to 31st May 2016 as they were approaching or had reached 18 years were included. Those young people who were discharged to child mental health services were not included, as this study focussed particularly on transitions from child to adult and community services.

Each site was asked to retrieve the relevant cases and identify these patients in order to gain access to the information needed regarding transition to adult services including community and custody discharges. Then, this information was accessed and retrieved electronically to complete the case note reviews. The researcher had to ask for special permission to access patients' notes-each site followed different protocols. Additionally, rates of actual were identified examining: time from referral until assessment, outcome of referral (discharge destination, continuity of care), characteristics of the cohort (diagnosis, legal status), process of transition (barriers or factors that fostered transition), and transitional pathway from previous placement to FCAMHS to adult services (TRACK, 2010).

First, the local collaborators or principal investigators from all hospitals were asked to identify all patients who had moved to adult mental health services during that period. The local collaborators had to coordinate with other staff members to identify and retrieve these cases. This task was not completed in a timely fashion due to infrastructural difficulties and clinical caseload. Therefore, the number of young people transitioned depended on this process and might be an estimate if cases were missed or records were missed. Even though records of young people were stored in a computerised recording system, some sites had not updated their systems and data relied on the responsible clinician's memory and notes. The average time of accessing these cases was about six to twelve months.

In the beginning, the hospitals would provide an Excel spreadsheet and usually the local collaborator contacting their secretary and asking them for the relevant data-annual transition numbers for that period. The numbers of annual transitions were low as it was expected. During my visits to the sites, I obtained electronic access to the personal records of patients discharged during the indicated time-period including forensic history, educational information, admission and referral processes. The information was protected and anonymised and the responsible clinician was present during data collection and case retrieval. There were no central databases

and the clinicians were asked to identify eligible patients, as I could not search the computerised systems using key criteria. However, this process lasted from August 2016 to May 2017, as access to retrospective cases was very challenging. Each hospital followed their own policy regarding patient information access and I had to go through several ethics procedures to ensure confidentiality. Additionally, some sites had to be visited multiple times due to technical difficulties. Coordination with IT workers and local collaborators when visiting had been troubling. Due to the sensitive information of data each Trust had its own strict policy to protect patients' personal information and accessing data embedded several difficulties, as described above. Four hospitals provided electronic access whilst two provided printed copies. All identified cases are based on the information handed by clinicians or other staff who had access to the relevant information. Similarly to TRACK, the lack of central databases significantly delays the research process and puts at risk the accuracy of data (Singh *et al.,* 2010).

This case note review examined the transition processes and outcomes for each site to compare them and find out any similarities and/or differences. Consistency in data was expected throughout the national system as all adolescent units discuss each week their existing and new cases together aiming to effective liaison and resolution of any issues.

The cases were not expected to differ significantly taking into consideration that inpatient FCAMHS admit a very particular subgroup of young people with complex and multiple needs. Yet, differences were anticipated regarding historical markers and transition destinations.

4.4.3.3 Sample

The sample for Phase 3 of the study looked at all young offenders who had reached the transition age boundary and had transitioned to adult mental health services including inpatient hospitals, community settings and

custody during the last year were identified. The transition age boundary according to the previous mapping exercise study for national FCAMHS is 18 years. Yet, services can keep young people until their 19th birthday. However, the sample included those who reached the transition age boundary of 18 years and over and transitioned to adult and community services and those who did not reach the transition age boundary and were less than 18 years and moved to adult services. Each hospital was asked to retrieve the relevant cases notes in order to gain access to the information needed with regards to transition to adult services. I visited each site and completed the reviews independently. Data were extracted and entered into Stata software 14.1.

4.4.3.4 Case note proforma

I used a predefined structured framework to extract data from the young people's hospital records. Due to the paucity in the current literature on methodological designs in forensic populations, I used a generic proforma from research conducted in routine CAMHS that was adjusted to the needs of this research study. Case note reviews have been used to understand and present clinical cases and to review patients' records in health research. However, most available case note review research has focussed on patients with medical conditions. In this study, case note review was not used to evaluate the quality of services but instead to map the care-pathways of young people admitted to FCAMHS and transition outcomes alongside the clinical and demographic characteristics of the eligible sample. For the purposes of this study the TRACK questionnaires for actual and potential referrals (including patient information) were used that targeted information about the young person's background including education, family, contact with social services and the youth justice system, diagnosis and clinical characteristics, previous placement, and discharge destination (Singh *et al.,* 2010). This proforma was initially designed and successfully implemented in the TRACK study that looked at transitions from child and adolescent mental health services to adult mental health services in non-forensic contexts. The proforma was used as a template and a guide to the transition outcomes this study should be looking at. For

the TRACK study, two proforma questionnaires were designed separately for actual and potential referrals to adult mental health services. However, in forensic child and adolescent mental health services young people cannot really be turned down by services and even in cases whereas services refuse to take over young people, another suitable service has to identified. This is in line with a section of the Mental Health Act that protects the rights of every young person regarding necessary Aftercare. This section is called 117 Aftercare and refers to those people detained previously in hospital under sections 3, 37, 47 and 48 of the Mental Health Act. I used a modified questionnaire based on the actual referral TRACK proforma. However, not all questions could be answered due to missing information from the case notes. The records and amount of information for each young person varied considerably, as majority of them had been moving across and within numerous services from an early age and FCAMHS databases did not contain all background information regarding each young person's forensic, medical and psychiatric history. Further, each NHS Trust is using different computerised systems to store information. Most of the data were retrieved from discharge summaries that I had access to. Therefore, small summaries are provided for all 32 young people with information I could retrieve from their records.

4.4.3.5 Data analysis

Documentary analysis was the main methodological approach used for this case note review. I studied each case separately and thoroughly and then extracted the information of interest. I extracted data from case notes based on the initial proforma. First the proforma was filled out and then 32 case notes were summarised. The cases were read multiple times to identify similarities and differences among the young people in terms of their characteristics, backgrounds, and particularly, their transitional pathways. The case note reviews were quantified to extract information such as demographics, diagnosis, family background, and transitional pathways. Descriptive statistics were used to present frequencies and annual rates of transitions along with demographics, diagnoses, offence

index, transition destination, transition pathway, parental mental health, educational status, past abuse, and length of stay. Descriptive analysis was performed to report rates and proportions of referrals for the preceding year. Annual transition rates were calculated along with demographics such as gender, ethnicity and age at time of referral to adult services and community, index offence, Mental Health Act Section and transition destination. These data were analysed with Stata 14 software to look for frequencies and percentages. Then, a care-trajectory was developed for each young person to identify any transition patterns including previous placement, FCAMHS and adult discharge destination. This was based on the information I had for each case, which varied from patient to patient. Each patient's background was summarised as a short case note/vignette to look for patterns regarding their characteristics etc. and some sample case note summaries are displayed in the results. Responses from the proforma were analysed with STATA software to calculate descriptive statistics.

Collective case study was used as a secondary methodology for this stage. The term collective is used because I looked more than one case. I used both descriptive statistics-quantitative and qualitative methods to show the magnitude and individuality of the transition's problems. The use of mixed methods helped to understand the practical and technical aspects of transitions in terms of numbers (e.g. annual transition numbers). The qualitative use facilitated an in-depth understanding through holistic exploration of each case based on the information provided. Each case study was the unit of analysis.

Currently, there are three main epistemological approaches followed by researchers when performing case studies analysis: critical, interpretative, and positivist (Table 12). However, it is recommended that in healthcare research more than one approach be integrated together (Crowe *et al.,* 2011). The results included 32 cases that shared similarities and differences with the annual cohort. This study also used an instrumental

approach to shed light on the general problem through understanding each specific case (Shkedi, 2005).

Table 3. Epistemological approaches on case study analysis adapted by (Crowe *et al.,* 2011)

Approach	Characteristics
Critical	*Involves questioning one's own assumptions. Interprets the limiting conditions in relation to power and control that are thought to influence behaviour.*
Interpretative	*Involves understanding meanings/contexts and trying to understand individual. Focus is on theory building.*
Positivist	*Involves establishing which variables one wants to study in advance and check whether they are in line with the findings. Focus is on challenging and refining theory of case study findings.*

Nonetheless, thematic analysis was used to identify codes and themes across the 32 cases. A constant comparative approach was carried out to identify common themes among all cases. Comparative analysis is commonly used in data driven research and in this case I performed cross case analysis that leads to new knowledge (Khan, 2008). Cross-case analysis contributes to learning from a set of cases.
Khan and VanWynsberghe (2008) highlight:

"To mobilize case knowledge across subject domains and across communities, we introduce the creation of a novel database."

A variable-oriented approach that focussed on specific variables leading to particular outcomes and pathways has been adopted. Due to the complexities embedded in each case, I also followed the case-oriented approach to create a story-narrative that has a meaning (Khan and VanWynsberghe, 2008).

Yet, these data were not retrieved by interviews and personal interaction with the participants was missing, the collected information relies mainly on

the written clinical histories by other healthcare professionals. I selected seven case studies that share similarities and differences to pint out the uniqueness of these cases as suggested by (Khan and VanWynsberghe, 2008). The approach in these selected cases is case-oriented as this approach is adopted to analyse cases that vary. Variable-oriented approach was carried out for all 32 cases to identify the similarities they shared. The selected illustrated case notes underscore the traumatic backgrounds of these young people and the multiple risk factors linked to offending and poor mental health. This method helps to identify constructively and holistically the transition pathway and, specifically, how this unfolds. This design is commonly used in health care to address a particular problem and identify current gaps (Crowe *et al.,* 2011). The steps taken to design and analyse this study are described in detail to eliminate biases and increase transparency.

4.4.4 Phase 4- Exploring the transition experiences of young people, families, and healthcare professionals across forensic child and adolescent mental health services

Phase 4 addressed this research question:
What are the views and experiences of young offenders, their carers and healthcare providers concerning the transition process?

4.4.4.1 The aims of Phase 4 were:

- to follow-up young people to adult placements;
- to explore the transition processes and outcomes based on healthcare professionals' perspectives;
- to explore young peoples' and their carers transition experiences;
- to understand and reflect on the young offenders' personal transition experiences across agencies in the criminal justice system and mental health services and, specifically from forensic child mental health to adult services and community;

- to identify barriers and facilitator to transition processes and outcomes;
- to understand the similarities and/or differences between child and adult mental health services;
- to explore transition preparation and management.

4.4.4.2 Sample

The technique of purposive sampling was applied. Key workers from different forensic mental health units either for adults (if transition was successful) or adolescents were interviewed to provide information about potential barriers and facilitators to transitions. Psychiatrists, nurses, occupational therapists, social workers healthcare support workers, and psychologists were included. Initially, I aimed to recruit 25 healthcare professionals from both adolescent and adult services. Once data saturation was reached data recruitment would stop. However, the sample was recruited based on availability and keenness on taking part in the study. The local collaborator would introduce me to the multidisciplinary team of each ward and I would explain the objectives of the research study. Each staff member was administered a participant information sheet, which I ran through on an individual or team basis. In some cases, I would speak to a number of staff members, such as five to 10 people, whilst in other occasions, I approached each healthcare professional in person. Then, those staff interested in the study, would approach me and discuss in more detail the study and arranging a date for the interview after they had provided written informed consent. Initially, it was expected that I would recruit 20 to 25 healthcare professionals in total that would meet the requirements of the study. Throughout the study, the sample size changed and participation from healthcare professionals increased due to major interest in transitions to adult services. The local collaborators facilitated the process of recruitment and their positive attitude towards the study had a positive impact on staff recruitment. Further, the recruitment of more healthcare professionals was necessary to reach data saturation but also

to include a wide range of views from a diverse body of professionals within mental health settings.

FCAMHS sample

Twenty-one semi-structured face-to-face interviews were conducted with healthcare professionals from FCAMHS. Questions targeted factors that interfered with:

- continuity of care;
- access to AMHS;
- effective communication;
- multiagency liaison;
- further recommendations for policy;
- resources to facilitate transition and continuity;
- skills and training necessary to improve staff confidence in provision of effective transition and continuity to users and carers.

The recruitment process aimed for an as much diverse sample as possible in terms of professional types. Certain types of professionals were underrepresented, such as occupational therapists and nurses. The most common type of involved professionals were psychiatrists due to staffing levels and acting as responsible clinicians for the young person. Nurses have high clinical caseloads and, therefore, were more difficult to recruit. The interview schedule is attached in the Appendices.

Adult services sample

Thirteen adult key workers were interviewed from forensic adult inpatient services and community services (receiving services) to identify:

- Barriers and facilitators in the transition process;
- to shed light on the interaction between mental health care and continuity of care for young people in transition of care.

The interviews with healthcare professionals from adult services included primarily the responsible clinicians (RCs) for the young person transferred to their services to:

- follow up patients' transition;
- understand the impact of transition on the young person.

When the RC was not available for an interview, another available staff member was interviewed, such as a health-support worker or primary nurse. The TRACK interview topic guide was used with some minor amendments as a topic guide that pertained mainly to the forensic nature of the services included in this study. The interview schedule is attached in the Appendices.

Five family members participated in the study and were interviewed before their child's transition. Permission was sought from the young people during distribution of participant information sheets. Family therapists or responsible clinicians from FCAMHS facilitated this process by contacting parents and carers (e.g. sending participant information sheets and consent forms through post) and asking them whether they would be keen on participating in the study. They were interviewed before their children's transition. Specifically, the parents or carers who had been or were living with the young individuals were sought for interviews. Their contact information was found from the FCAMHS responsible clinicians and local collaborators. However, permission was asked from the young people whether they would like their carers to be interviewed and involved in the study. Approximately 10 parents and carers were sought for interviews on the sites when available-usually in the weekends when they were allowed to visit their children.

I recruited 13 young people from four hospitals during the six-month period of May 2016 and November 2016. Four units were included out of the six. Young people from two units did not agree to participate at all although I visited these wards twice. I met the young people and explained the study in one of these two excluded wards. On the other ward, the eligible young people refused to see me both times. Their responsible clinician explained that were particularly upset due to their upcoming transitions and they would not be in a good standing to speak to me. The mapping exercise

identified 34 young people eligible for transition to adult and community services. However, there were recruitment difficulties and 21 young people did not wish to participate in the study. Those young people who did not take part in the study would either not meet with me when I was visiting FCAMHS or would refuse to take part after I had given them the study's leaflet and explained the purpose of the research. Some of those were mentally unwell and extremely stressful due to their prospective transitions (as their clinician would explain) and could not really understand the content and purpose of the study. Purposive sampling was applied by identifying potential participants in a consecutive manner. Purposive sampling was adopted because this study aims to recruit a very specific sample from FCAMHS that met the criteria of the study:

(a) be close to the age transition boundary to move to adult services;
(b) be beyond the age transition boundary to adult services -over 18 years.

Accordingly, the sample selection was based on the characteristics of the group and, more specifically, age. For the purposes of this study's aims and objectives, purposive sampling was appropriate.

4.4.4.3 Data collection

Thirty-four healthcare professionals across all six forensic FCAMHS and nine adult services including both inpatient and community settings were recruited to explore their experiences and to learn the structural and organisational components of services. Twenty-one semi-structured face-to-face interviews were conducted with healthcare professionals from FCAMHS and 13 with adult services (receiving services) to identify organisational and structural difficulties in transition process and to shed light on the interaction between mental health care and continuity of care for young offenders. The interviews with healthcare professionals from adult services included responsible clinicians (RCs) for the young person transferred to their services to follow-up patients' transition and understand through the clinician's view the impact of transition on the young person. In cases where the RC was not responsible for an interview, another available

staff member was interviewed and that would be their health-support worker or primary nurse. The different mental health hospitals were visited along with community settings. The TRACK interview topic guide was used with some minor alterations that pertained mainly to the forensic nature of the services included in this study. The questions targeted factors that interfered with continuity of care, access to AMHS, effective communication, multiagency liaison, resources enhancing smooth transition, the role of staff in this process, and further recommendations for policy. Also, other examined transition elements included approaches to teamwork and decision making within and across organisations; resources to facilitate transition and continuity, role development, skills and training necessary to improve staff confidence in provision of effective transition and continuity to users and carers.

FCAMHS data collection

An introductory visit was scheduled for each site to meet with the Local Collaborator or Principal Investigator representing each site for the study. For five services the corresponding key contact was a consultant forensic child and adolescent psychiatrist and in one site this person was a consultant forensic child and adolescent psychologist. All FCAMHS healthcare professionals agreed to be audio recorded.

Adult services data collection

After young people moved to adult services and community placements, I was notified by their RC in FCAMHS about their discharge destination and their RC's contact details at the receiving service in order to follow-up. Responses from services varied and follow up ranged between one and five months upon transition. I had to travel to nine different geographical locations across England to follow up with young people and their adult key workers including nine secure forensic adult secure hospitals and two community supported accommodation settings.

The time of follow up for young people varied depending on several factors, such as coordination with adult services and their responsible clinician in

FCAMHS and receiving services and availability of clinicians. The responsible clinician from FCAMHS would provide me with the contact information of the adult responsible clinician or the ward manager. Thereafter, I would send an email to the above contacts explaining the purpose of the study along with the study's leaflets in order to arrange a follow up visit. Responses ranged from one week to three months and it would usually take one additional month to visit the placement. Visits varied between one to five months post-transition. Questionnaires were prepared and piloted with some NHS patients. These participants had been selected and identified by healthcare professionals from Phase 2 -the mapping exercise. Adolescents aged 17.5 years and adults aged 18 to 19 years after being transferred to adult services were interviewed. The young individuals participated after they had provided informed consent whilst in FCAMHS. Individuals who lacked capacity to provide consent due to mental and/or neurodevelopmental problems or due to acute phase of their mental illness were excluded.

Family/Carers

Family therapists or responsible clinicians from FCAMHS facilitated this process by contacting parents and carers and asking them whether they would be keen on participating in the study. Families of the young people were not easy to reach due to several reasons, such as geographical location (Dent *et al.,* 2013), lack of involvement and distrust to services and possibly shame due to the offence committed by the young people. Discussing their children's transition would entail some elements from their forensic history that could induce strong feelings during the interviews. Parents and carers have to be involved throughout the judicial process and when the young people are facing charges against them and they have to cope with grief, shame, trauma and loss. Ten parents and carers were approached to partake in the study. However, five of them did not respond back despite being sent invitation letters by responsible clinicians alongside the participant information sheets.

An interview study guide (similar to TRACK's) was created including about 10 standardised questions. Semi-structured interviews were conducted to understand the particular transitional experiences of the young person and their parents/carers examining the transition process and their feelings towards it, the organisational and structural components of transition. The questionnaires asked for their feelings and levels of satisfaction, evaluated their relationships with healthcare providers, and looked for recommendations to improve current service delivery and mental health care in FCAMHS and discharged adult services. Specifically, preparation for transition, experience of transition and outcomes were explored.

Young people

Those young people who were interviewed moved to adult services at different times and the time I visited them ranged between a month and six months after their transition depending on situational factors, such liaison with adult services and their responsible clinicians mainly in the receiving service. Two of the participants had not moved by the study's end date due to multiple complexities based on their mental and legal status and infrastructural weaknesses in adult services (lack of bed availability). Therefore, I visited these patients in FCAMHS to understand on how transitional delay had affected them or not. The study's end date was 05/01/2018, which meant that these young people were in FCAMHS for more than a year after their 18th birthday. The remaining 10 young people moved to nine different adult placements including low, medium and high secure services, community support accommodations and forensic community mental health teams. Two people from the same ward moved to the same forensic medium secure hospital. The adult placements were in nine different geographical locations usually in the patient's catchment region but not always. Four young people did not move to their catchment area due to lack of available services in the local area. Including the FCAMHS and forensic AMHS, I involved 13 hospitals and three community placements across England.

Young people were followed up in adult services either hospitals or community placements. They were identified before with the use of the mapping tool that included all potential participants close to the age boundary or had already reached the transition boundary within a six-month period. This cohort was visited in advance at each hospital whilst they were still in forensic child and adolescent services. Their responsible clinician and I approached the young people to explain the study and ask whether they would like to be followed up when they move to adult services. A participant information sheet was administered to read. In case, they had any questions regarding the study procedures, I elaborated on further details and provided relevant clarifications. If the patients agreed to participate in the study, they were given a consent form to sign and were asked again whether they would like me to visit them once they move to adult services. Special groups with complex needs, such as those with learning disabilities required more help with reading and understanding the context and, therefore, the present clinician and I responded accordingly by reading them loud the leaflets and/or repeating, simplifying certain questions of the consent forms. In some hospitals, I had to introduce the study to all eligible young people together whilst in other units, I would speak to each young person individually. All the wards were visited multiple times to recruit young people and I would see the young person at least two times before they agreed to participate. For instance, I was invited twice in one ward during their weekly community meetings to speak to the group of young people and staff members about the research study. Still, they did not agree to be followed up after being discharged from FCAMHS. The whole group of the six eligible young people mentioned that they did not wish to participate. In another unit, the local collaborator suggested I visited on a different day the same young person since they were experiencing a bad day. I worked closely with the local collaborators to enhance recruitment and explain the rationale of the study to the young people and how participating would benefit future cohorts and would also inform policy. Yet, considering their circumstances, risk, vulnerability and comorbid mental health problems, and engagement was extremely difficult. For instance, some of these people seemed hopeless and very worried

about the future including transition delays and tribunal outcomes. The burden of legal and medical contexts could explain the low engagement. However, one specialising unit in learning disabilities was included, two mixed, and one male only unit. The ones excluded due to lack of participation were:

- one-unit specialising in learning disabilities;
- one male only unit.

Table 4. Types of healthcare professionals interviewed across mental health settings

Interviewees	Number
FCAMHS key workers	
Psychiatrists	9
Psychologists	5
Social workers	2
Nurses	2
Family therapists	2
Occupational therapist	1
Adult key workers	
Psychiatrists	9
Psychologist	1
Social worker	1
Nurses	1
Health support worker	1

4.4.4.4 Data Analysis

Interviews were face-to-face and audio-recorded with the permission of the participants and then transcribed using thematic analysis to look for patterns in the participants' answers. Interviews with healthcare professionals were audio-recorded and then transcribed using thematic analysis to look for patterns in the participants' answers. Only four interviews were not audio-recorded due to ward restrictions pertained to medium and high security levels. Thus, notes were taken during the interview process. Transcripts were read multiple times to identify emerging

patterns and trends including differences, similarities, contradictions, repetitions, summaries, and use of language. A codebook was developed including encoded and predetermined terms such as continuity/discontinuity of care, liaison among services, referral criteria, barriers/facilitators to transition, waiting time, staff training, structural/organisational barriers, service satisfaction, transition barriers/facilitators, family's role, continuity/discontinuity of care, service coordination, and healthcare professionals' flexibility. However, the theme of continuity of care was approached and interpreted differently for those individuals at risk for long-term or even lifetime institutionalisation in secure care. Continuity of care was approached as a two-fold theme having either negative or positive impact on the young offender's transition. The questionnaires asked for their feelings and levels of satisfaction, explored relationships with healthcare providers, and looked for recommendations to improve current service delivery and mental health care in FCAMHS and discharged adult services. Specifically, preparation for transition, experience of transition and outcomes were explored. I adopted a reflexive approach to understand and reflect on all issues brought up by young people. Therefore, after interviewing each young person I would write up a reflective summary on our semi-structured interview and reflections on their responses. Transcripts were analysed in MAXQDA software.

All young people cases are summarised, and the data is pseudonymised for confidentiality purposes. Interviews were audio-recorded with the permission of participants (young people and families) and then transcribed using thematic analysis to look for patterns in the participants' answers. In cases where participants did not wish to be audio-recorded, I was taking notes while talking with them. Even if they have agreed to be audio-recorded when they signed the consent form, I asked them again before the actual interview what method they feel more comfortable with. This group of young people is extremely vulnerable and has experienced multiple transitions throughout agencies usually from an early age. It is difficult for them to establish and maintain relationships and have developed distrust towards authority figures. Whilst they were reassured

multiple times about confidentiality and anonymity, it was expected that they would feel a certain level of distrust.

I used Thematic Analysis (TA) as my primary method given on the flexibility of this analytical method. The researcher can organise and describe their data in detail with interpretative input that allows for reflections through themes (Braun and Clarke, 2006). Thematic analysis in this context is an essentialist method, as the interviews express the young people's realities through their lenses. In this study, I adopted an essentialist or realist approach because the main concern was to hear from the young people and their systems and the ways they understand their own realities. However, at times a constructionist view was embedded, where the primary focus was the reality of participants but also the impact of the social context (current or past placements) on the meaning given to their realities (Braun and Clarke, 2006). Secure hospitals are confined environments that impact young people's views. Hence, I could not defy the effect of such powerful environments as secure hospitals and establishments and the fact that majority of these young people had been moving across such institutions since their childhood. Therefore, I used a *contextualist* approach as the main epistemological position, as proposed by Braun and Clarke (2006), which lies in between essentialism or realism and constructionism. I used both an inductive (data driven) and deductive (emerging from the literature) approach considering the *contextualist* approach I adopted for this study. The transcripts were scrutinised to identify patterns and select themes that were recurring, were of particular importance to the participant and fit into the research question and the general context of transitions. The analytical framework was based on latent analysis, as described by Braun and Clarke (2006), where an in-depth analysis takes place and aims to unravel latent content underlining the interviews. In this case, latent analysis elaborated on the semantic context and the development of conceptualisations. Latent thematic analysis pertains to interpretation and not merely description.
I followed the five steps, as introduced by Braun and Clarke (2006):

1) data familiarisation
2) initial code generation
3) theme searching
4) theme reviewing
5) theme definition and names
6) write-up

Figure 5. This figure displays the mode interviews were conducted based on services' restrictions and young people's wishes

4.4.4.5 Reflexivity

During the interviews I took notes and if the young person was not audio-recorded I took very detailed notes. Subsequently, I wrote reflective summaries as soon as possible after the interviews in the whole system that they had a reflective and interpretative character. The reflective summaries especially for those young people who were not audio-recorded helped to understand the young people's experiences more in-depth. Reflexivity aimed to develop an analytical and detailed approach for each young person and involved me in the process of interpreting the participants' reality. As Berger (2015) points out, the researcher is shaping the interpretation of the participants' experiences according to her personal experiences and backgrounds. Critical reflexivity helps the researcher to

recognise the friction between personal involvement and detachment and also enhances the validity of the research. Supervision meetings facilitated this process by discussing ideas and reflections and often providing an alternative view resulting from reflexivity process.

4.5 Ethics and Limitations

Phase 4 of the research study included several challenges, as young people in FCAMHS comprise a very sensitive group. Firstly, recruitment was particularly difficult and the sample size was small reaching only 38% of the desirable sample of young people. The number of young people recruited in this study was smaller than the number of healthcare professionals. The number of healthcare providers increased due to their keenness on participating and also for compensating for those young people who did not wish to participate. Yet, the sample included young people from four national services. I also included clinicians instead of young people for those services where young people did not agree to participate in the study to gain an understanding of the cases of those young people who refused to take part. Considering the small number admitted to FCAMHS annually in line with one unit's data that they had accepted 55 young people within a five-year period, the included sub-sample of young people in the interviews is justified (Dimond and Chiweda, 2011). In this study, each ward accommodated young people between 13 and 18 years and this study was interested in as ub-group of the ward population, those who were over 17.5 years, which varied between two and six young people from each unit. Some of them were not keen to meet with me and share any experiences whilst others were in acute phase of their mental illness and were secluded. Some other young people were frustrated due to transition delays and were reluctant on participating as their mental health had exacerbated during the process to problematic transitions. Taking into consideration young people's distrust into services along with their mental health and legal status, it is explicable that young people were not keen on sharing thoughts and feelings of frustration. The TRACK study included the same level of limitations.

Additionally, since many of the interviews took place in secure hospitals, young people were cautious in disclosing much information or their responses might be biased and affected by exogenous factors (i.e. authority figures). The majority of the young people were interviewed without the presence of a key worker and I would have an emergency alarm in case of an adverse event. For three young people, adult key workers had to be present during the interviews due to high-risk presentation. I was aware that these young people were in a restricted environment where their psychological well-being is at risk and might exacerbate their current mental health status and worsen their emotional well-being. Most importantly, the main ethical dilemma I faced was that of personal autonomy and freedom when collecting data (James, 2013). Further, I had to remind myself that my role as a researcher was to collect data that would contain sensitive context at times and I could not act upon this information unless safeguarding and abuse issues were raised.

4.6 Summary of the data set and design

This research study consisted of four interlinked phases including a systematic review, a mapping exercise, a case note review and qualitative interviews. This research study used a sequential exploratory mixed methods design to address the complexity of transitions across forensic inpatient settings with a methodologically robust design. The systematic review synthesised current studies from the existing literature quantitatively to examine the prevalence of mental disorders among young offenders with considering that a subgroup of these detained youths is transferred to FCAMHS. Meta-analysis and meta-regression were used to understand the role of the demographic characteristics on the prevalence of mental disorders in this group. The mapping exercise study followed to identify the number of young people transitioning to adult services within a six-month period. This tool helped to identify policy and practice across all FCAMHS and facilitated recruitment of young people. The retrospective case note review measured the annual transition rates and transition pathways of

young people who were discharged the previous year. Healthcare professionals from FCAMHS and young people's parents were interviewed pre- and peri-transition to understand transition preparation and transition views. The qualitative interviews with the young people were conducted to explore their experiences post-transition in adult and community services. Healthcare professionals from adult services were interviewed to reflect on the young person's transition and to explore transition outcomes. This mixed methods sequential exploratory study on transitions of young people from forensic child and adolescent mental health services to adult services aims to extend understandings on this topic. The following four chapters present the findings from the four phases of this study and each chapter addresses a different research question using a different method. The next chapter is a systematic review and meta-analysis on the prevalence of mental health disorders in young offenders.

5 Mental health problems in adolescent offenders: A systematic review and meta-analysis

"If the children we have in our prisons are not in need of such 'specialist provision,' why on earth are they in detention?"

(Willow, 2015: 34)

5.1 Chapter overview

This chapter is going to examine the prevalence of mental health problems through a systematic literature review. The literature review in Chapter 3 demonstrated the paucity of literature in this area in the last decade and the lack of a recent systematic review and meta-analysis in the area.

5.2 Research question

What are the demographic characteristics and prevalence of mental health disorders in young offenders in transition?

5.2.1 Aims

The main aims of Phase 1 were:

- to calculate pooled prevalence rates of a range of mental health problems (affective disorders, personality disorders), self-harm, suicidal behaviour, and learning disabilities among male and female young offenders;
- to determine the potential moderators of prevalence rates in terms of individual characteristics (age, gender, ethnicity) and study methodology (sample size, setting, study quality).

5.3 Introduction

Incarcerated youth are three times more likely to have a mental disorder than young people in the general population (Prison Reform Trust, 2012).

According to a UK national study, 95% of incarcerated youth between 16 and 20 years had at least one mental disorder, while nearly 80% had comorbid mental health difficulties (Lader *et al.,* 2000). International studies also demonstrate a high prevalence of mental health problems in this group (Colins *et al.,* 2010).

Previous reviews have reported a high prevalence of mental disorders and symptoms among youth in custody, though they have focused on a narrow range of diagnosed mental disorders (Colins *et al*. 2010; Fazel *et al.,* 2008). Fazel and colleagues (2008), conducted a meta-analysis of the pooled prevalence of some mental disorders including major depression, psychotic illness, conduct disorder and Attention Deficit Hyperactivity Disorder (ADHD) in juvenile detention and correctional facilities. Colins et al. (2010) considered a wider range of mental disorders such as Oppositional Defiant Disorder (ODD), Post-Traumatic Stress Disorder (PTSD), separation anxiety disorder (SAD) in male samples only, but again did not examine learning disabilities (LDs), emerging personality disorders (PDs), self-harm and past suicide attempts. PDs are highly prevalent in adult offender populations (Fazel and Danesh, 2002) and there is growing awareness of the clinical importance of PDs, and associated symptoms, such as self-harm and suicide attempts in younger populations (Shiner and Allen, 2013). However, the clinical diagnosis of PDs in adolescents is quite controversial. An increasing number of studies suggest that clinical symptoms of Borderline Personality Disorder (BPD) manifest during adolescent years (Kaszynski *et al.,* 2014). A recent study among female adolescent offenders in a UK forensic inpatient unit, revealed that emerging BPD was prevalent among two thirds of the sample (Hill *et al.* 2014).

Suicides in custody amongst youth 15 to 19 years are 3 times higher than the general population (Gallagher and Dobrin, 2006). Yet, prison could be seen as a protective factor towards suicidal attempts amongst young people. As Gallagher and Dobrin (2006) highlight young people in detention settings present such a high-risk to self that they could have died if not confined. The role of prison can be described as protective at times to accidental death. A

few studies have linked past suicide attempts with major depression and anxiety disorders (Abram et al., 2008). Gender differences have become apparent with females manifesting suicidal symptoms much more frequently than males in secure settings including secure units, as a recent literature review stresses (Hill *et al.,* 2014). However, adolescents in secure settings will receive a diagnosis of mood and conduct problems in case of self-harming and suicidal behaviour.

Previous studies have identified LDs among incarcerated youth as a major concern (Chitsabesan and Bailey, 2006)

LDs amongst youth in custody are quite common, with between 23-32% of incarcerated youth having a generalised learning disability compared to 2-4% in the general population (Hughes, 2012). A large study including 301 justice-involved youth from secure settings and the community reported that about a quarter, had LDs that were identified with IQ scores below 70 and a third had borderline scores varying between 70 and 80 (Harrington *et al.,* 2005). LDs have been linked to antisocial behaviour and to ADHD and for some to criminal behaviour (Penner *et al.,* 2011). The inadequacy of the school system to support young people with LDs reinforces offending behaviour at a very early life stage where young people seek acceptance from delinquent peers (Einat and Einat, 2008).

PDs are highly prevalent in adult offender populations (Joseph and Benefield, 2012) and there is growing awareness of the clinical importance of PDs, and associated characteristics, e.g., suicidal behaviour (Winsper *et al.,* 2012) in younger populations (Winsper *et al.,* 2016).

However, the clinical diagnosis of personality disorders in adolescents is quite controversial. An increasing number of studies suggest that clinical symptoms of Borderline Personality Disorder (BPD) manifest during adolescent years. A recent study among female adolescent offenders in a UK forensic inpatient unit revealed that emerging BPD was prevalent among two thirds of the sample (Hill *et al.* 2014). Similarly, there is limited

research examining learning disabilities among young offender populations (Loucks, 2007). Therefore, to further our understanding of mental health problems in young offenders, we should also consider a broad spectrum of mental health problems. To the best of my knowledge, this is the first review to compute pooled prevalence rates of self-harm, suicidal behaviour, emerging personality disorders and learning disabilities.

There is a controversy whether young people should be diagnosed with personality disorders before the age of 18 (Hill *et al.,* 2015). Some research underscores that symptoms, which appear during adolescence, might not persist into adulthood (Guilé and Greenfield, 2004). Nonetheless, some studies show that incarcerated youth presenting with antisocial and borderline symptomatology meet the criteria for clinical diagnosis (Kaszynski *et al.,* 2014). In case these symptoms linger untreated until adulthood the risk of reoffending increases (Johnson *et al.,* 2014). Other studies in community population are in line with these findings and corroborate that BPD can emerge during adolescence and early diagnosis could have long-term benefits (Winsper *et al.,* 2016).

Mental health services for such populations have been described in the extant literature as being inadequately resourced (Chitsabesan *et al.,* 2006). Therefore, to increase our understanding of mental health needs amongst incarcerated youth, we should also consider a broad spectrum of mental health disorders, problems, difficulties and associated symptoms. To the best of our knowledge, this is the first review to compute pooled prevalence rates of self-harm, past suicide attempts, emerging PDs and LDs in this population.

If we are to meet young people's needs and ensure recovery, reduce recidivism and promote functional independence, then we need to provide adequate care. Therefore, there is a need to understand the nature and magnitude of their needs. Hence, it is necessary to examine diagnosed mental disorders, emerging mental disorders, symptoms and LDs along with more commonly studied and diagnosed mental disorders.

When considering the prevalence of mental disorders and symptoms within incarcerated justice-involved youth, it is important to consider potential moderators, which may impact on figures. For example, the prevalence of mental disorders can vary depending on age. Age relativity might be significant when diagnosing a mental disorder. Younger offenders are more prone to disruptive behaviour disorders, such as conduct disorder (Karnik *et al.,* 2010).

Previous research has underscored that mental disorders vary by ethnicity (Shelton, 2004). Accordingly, one large study assessing psychiatric disorders among detained youth found higher prevalence of mental disorders among white groups than ethnic minorities (Teplin *et al.,* 2002). An understanding of ethnic variations in mental disorders may be useful in informing culturally appropriate interventions for incarcerated young people (Karnik *et al.,* 2010). In the years 2014/2015 the number of young male offenders in Youth Offending Institutions coming from BME groups has been twice as high as a decade earlier indicating a demographic shift in UK child custody (Hazel and Lockwood, 2016).

Gender differences in prevalence rates have been mentioned in the literature across community and custody samples. Fazel et al. (2008) in his review reported gender variations too. According to the study's findings, major depression was prevalent in 29% females and 11% males, ADHD in 19% females and 12% males while there were only slight gender differences in conduct disorder and psychosis. Overall, there are not enough studies including female justice-involved youth population in the literature and there are fewer studies on juvenile female psychopathology than on male offenders, as a much smaller number of incarcerated females exists (Dixon *et al.,* 2004).

5.4 Search strategy

The search terms were decided by consulting related systematic reviews and conducting a pilot search (Colins *et al.,* 2010; Fazel *et al.,* 2008). I

searched MEDLINE (1946-August 2016), Embase (1947-2015), Psych INFO (1923-2016), and Web of Science (all years) combining the following key words: (juvenile* OR adol* OR young* OR youth* OR boy* OR girl*) AND (offen* OR prison* OR jail* OR incarcerat* OR custod* OR imprison* OR detain*) AND (mental health OR prevalence OR suicid* OR depress* OR CD OR ODD OR ADHD OR PTSD OR personality disorder). References from relevant papers were searched and 1 additional study was retrieved and included in our review (Steiner *et al.,* 1997).

In case of missing data or methodological insufficiencies, the authors of the primary studies were contacted. The database search was completed on 30th August 2015. The MOOSE (Stroup *et al.,* 2000) guidelines for Meta-Analysis of Observational Studies in Epidemiology were used. Literature search results were uploaded to Endnote library that is a reference manager-software, to facilitate information share between reviewers during the study selection process. Neither of the reviewers was blind to the journal titles or to the study authors or institutions.

5.5 Protocol and registration

The review protocol was registered with the PROSPERO International Prospective Register of Systematic Reviews on 27 November 2015 and can be accessed via the PROSPERO website at http://www.crd.york.ac.uk/PROSPERO. The PROSPERO registration number for the review is CRD42015029677.

5.6 Study selection criteria

Search screening was based on the inclusion and exclusion criteria already determined for the study. This review included juvenile and young offenders 19 years and younger both females and males with a history of offending and ongoing mental health problems who were in detention. We included studies that used diagnostic tools and/or structured or semi-structured psychiatric surveys according to the DSM-III or IV or IV-TR or V and ICD-10 criteria. The most well-constructed DSM diagnostic interview is the Diagnostic Interview Schedule for Children (Grisso, 2004) (DISC),

which has been used extensively in detained youth. Research using the Voice DISC that is the computer version of the diagnostic tool was not included in the review, as the value of the clinical judgment outweighs the practicality and anonymity of the computerized interview.

Studies using only symptom inventories, such as the Massachusetts Youth Screening Instrument (MAYSI), and measures for functional impairment, such as the Global Assessment of Functioning (GAF), for diagnostic purposes were excluded. However, self-reports for PTSD, self-harm and suicidal behaviour, operationalized as past attempts, were included in the present study. Depending on the disorder, I looked at current (1 week, 1 month), period (6-12 months), and lifetime prevalence. Suicidal attempts at any point were looked as lifetime. I had to include at least three studies on a particular disorder to present results on a forest plot. Only studies written or translated in English language were included. Substance abuse problems were not included if they provided the primary disorder as the results would be inflated given the extremely high rates of use/abuse in this group. Systematic reviews, case studies, intervention studies, and editorials were excluded.

5.6.1 Search criteria

I was interested in the prevalence rates of a wide range of mental health problems, and additionally, past suicidal behaviour and self-harm. I included: affective disorders (depression, dysthymia, panic disorder, social phobia, special phobia, separation anxiety disorder, generalized anxiety disorder, obsessive compulsive disorder, PTSD), psychosis (schizophrenia, psychotic symptoms), disruptive behaviour disorders (conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder), learning disabilities (based on IQ results) and personality disorders (borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, schizoid personality disorder).

5.6.2 Study selection criteria

Inclusion Criteria:

- offenders aged 10 to 20 years-based on definitions of young offenders) Singleton et al., (1998) and Lewis and Samuel (2013);
- detention (on remand or sentenced), community, or inpatient populations;
- diagnostic tools and/or structured or semi-structured psychiatric surveys according to the DSM-III,IV,IV-TR or V, and ICD-10 criteria;
- self-reports for self-harm, suicidal attempts;
- primary studies only;
- English studies only.

Exclusion Criteria:

- research using the Voice DISC-computerised version for self-administration -limited to identify misinterpreted questions without the presence of a clinician (Schaffer *et al.,* 2000);
- studies using only symptom inventories, such as the Massachusetts Youth Screening Instrument (MAYSI);
- primary substance abuse problems due to biased sampling (Fazel *et al.,* 2008).

5.7 Data Synthesis

A quantitative synthesis was carried out to summarise the results of the studies included in the review. Meta-analysis was chosen as the primary analysis method to provide pooled estimates of mental health problems amongst young offenders. Levels of heterogeneity were expected; however, the studies did not differ to such an extent that a meta-analytic approach could not be performed. All studies were cross-sectional in terms of study design and measured the prevalence of mental disorders in young offenders whereas mean age varied between 14 and 18 years.

5.8 Heterogeneity

Heterogeneity determines consistency in the studies along with the extent of the results' generalizability (Higgins *et al.,* 2003). Heterogeneity was expected in the prevalence estimates since different studies use different diagnostic tools, types of interviewers, number of participants and the samples were expected to present heterogeneity depending on the setting. Yet, a certain level of prevalence consensus was expected with the existence of some outliers. Meta-regression was carried out to explore which factors have contributed to the heterogeneity results and have affected the effect size and to investigate between study variance.

Cochran Q and I^2 statistic are used to explain heterogeneity and variance. Cochran Q is presented with χ^2 value (Fazel *et al.,* 2008). The I^2 statistic indicates whether there is actual heterogeneity with values of 25%, 50%, and 75% highlighting the level of heterogeneity (Young *et al.,* 2015). However, Cochran Q does not represent a highly reliable method of measuring and determining heterogeneity among studies taking into account that a meta-analysis does not consist of a satisfactory number of studies (Higgins *et al.,* 2003).

5.9 Statistical Analyses

5.9.1 Meta-analysis

I computed the pooled prevalence of mental health problems in STATA 14.0 using the *metaprop* command (Nyaga *et al.,* 2014). Overall prevalence was computed for each mental health problem, and then stratified by gender. This command was recently introduced and has been significantly helpful in meta-analysis for prevalence studies by using the actual prevalence number, as a nominator and, the sample size, as denominator to compute prevalence proportion. We used the random effects model, as the levels of effect sizes were expected to vary. Overall prevalence was computed for each mental health problem, and then stratified by gender. Forest plots present prevalence rates with assigned

study weights and 95% confidence intervals (CI) in the form of forest plots. The CIs represent the actual prevalence proportion.

5.9.2. Meta-regression and subgroup analysis

The causes of significant heterogeneity in prevalence estimates across studies were examined with sub-group and meta-regression analysis. Sub-group analysis facilitates a graphical comparison of pooled prevalence rates between sub-groups (e.g., female versus male). Meta-regression expands on these findings by providing a statistical test of whether each sub-group factor is significantly related to variations in prevalence (Higgins and Thompson, 2002).

Several factors were identified based on the extant literature as having the potential to influence prevalence rates. Sample characteristics included gender (Dixon *et al.,* 2004), age (Karnik *et al.,* 2010), and ethnicity (Shelton, 2004). Study methodology features comprised assessment tool (Fazel *et al.,* 2008), time frame of prevalence (Grisso, 2004), sample size (Fazel *et al.,* 2008) and study quality - based on the Joanne Briggs Institute (JBI) Critical Appraisal scores (Munn *et al.,* 2014).

I dichotomized (with 0 as the reference category for the meta-regression analysis) characteristics as follows: gender (male =0 versus female =1), sample size (small n<100 =0 versus large n ≥100=1), age (<16 years =0 versus >16 years=1), setting (detention = 0 versus non-detention=1), and study quality score (high ≥ 7 =0 and low score <7=1), and trial status (pre-trial = 0 versus post-trial=1). We entered time frame of prevalence (point=0, period=1 and lifetime prevalence=2) as a categorical variable.

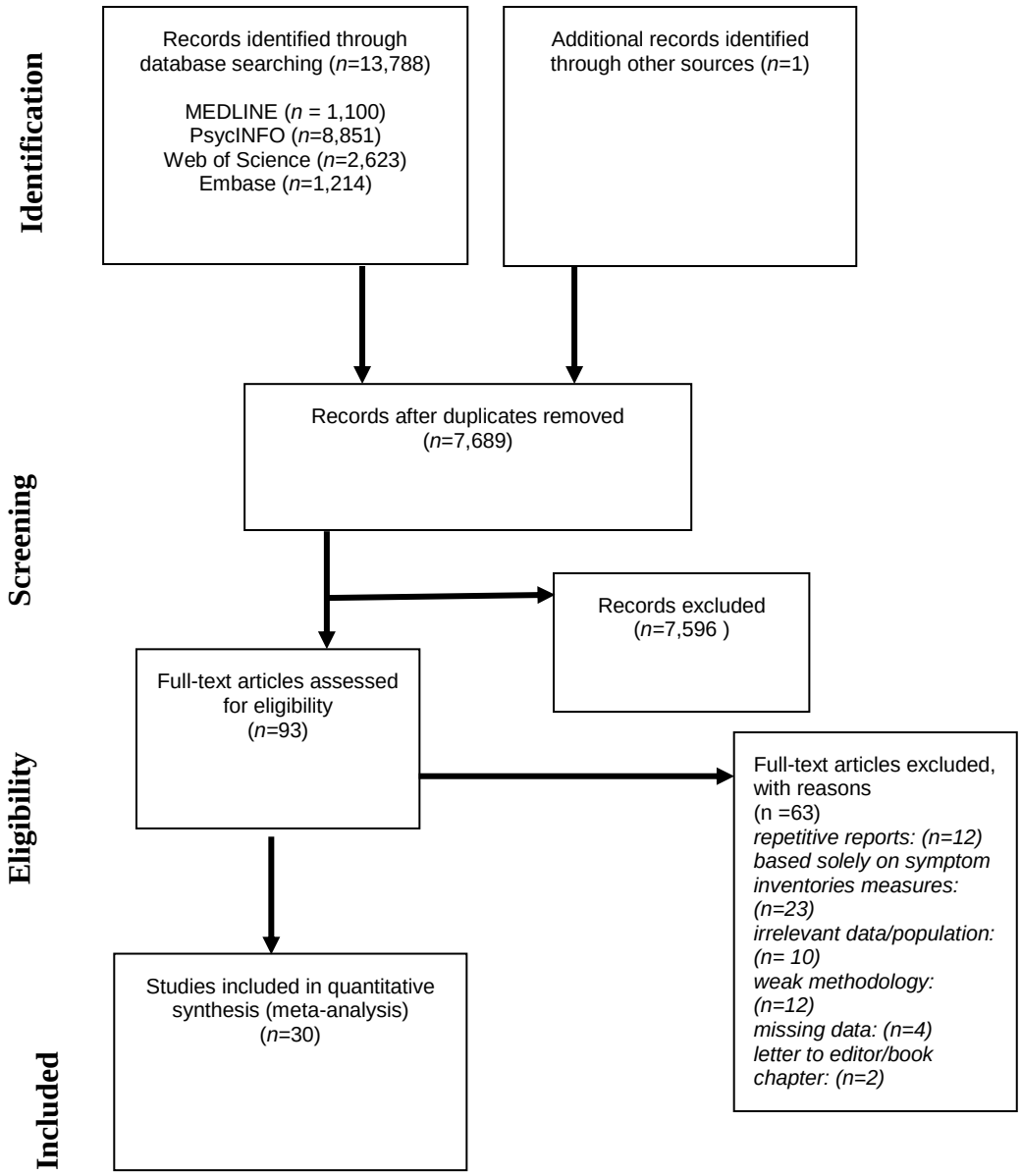
For meta-regression, I performed univariate analysis for each mental health problem and potential moderating factor (i.e., each moderating factor was entered individually). If any of the moderating variables were significantly associated with heterogeneity, they were entered into multivariate meta-regression analysis to test their independent effects while controlling for other moderating factors (Higgins and Green, 2008).

5.10 Results

5.10.1 Description of studies

I identified 7,689 articles eligible for screening after duplicates were removed. ML independently screened 100% of the titles and/or abstracts to identify studies for full text retrieval. AS screened 60% of the abstracts and titles as a reliability check. Inter-rater reliability was good (kappa=0.89). Based on title and/or abstract 7,596 articles were excluded.

Figure 6. PRISMA Flow Diagram outlining screening and searching process



The PRISMA flow diagram presents the results of the electronic database search. The database searching returned 13,788 articles initially; 7,688 articles were screened when duplicates were removed. Ninety-three articles were eligible for full-text retrieval and 60 of these were excluded leaving 30 articles for final inclusion. One study was selected after searching the reference section of an included article (Steiner *et al.,*1998).

The reviewers agreed with the all selected articles but one that was added for data extraction and quality assessment (Timmons *et al.,* 1997). ML and AS read the 93 full text articles for final inclusion in the review and performed a methodological quality assessment for all 93 selected articles in accordance with the JBI Appraisal Checklist for Studies Reporting Prevalence Data. Inclusion in the review required that studies reached a score of at least '6.' The reviewers agreed on the cut-off score before the critical appraisal (Aromataris *et al.,* 2014). The process of the quality assessment ensured that included studies met the desired methodological quality criteria for: the statistical analysis each study performed, assessment tool used, sampling method, sample size, sample representation, and study objectivity. Sixty studies were excluded based on study quality. Thus, thirty studies were included in the final review (see Figure 6).

Some articles were excluded based on title and/or abstract. If it could not be decided from reading the abstract, whether the study met the inclusion criteria then full text articles were retrieved and read to assess for inclusion in the review. Quality appraisals were performed independently for all 93 selected articles in accordance with the JBI Appraisal Checklist for Studies Reporting Prevalence Data. To establish reliability the two reviewers both assessed the first 40 studies randomly (47%) and then they split the remaining articles assessing 53% each. They also adhered to the MOOSE guidelines throughout the review. The process of the quality assessment aimed to tackle any potential risk of bias regarding the statistical analysis each study performed, sampling method, sample size, sample

representation, and study objectivity. The critical appraisal checklist consisted of 10 questions that the reviewer was called to answer with ‘yes’ or ‘no’ and ‘unclear’ or ‘not applicable.’ Studies that did not reach a score of ‘6’ were excluded after being discussed with both reviewers. The lead reviewer made the final decision whether the study would be part of the final inclusion or not.

5.10.2 Data extraction

A data extraction form was created with a table displaying summarised results by authors, sample size, participants (gender, ethnicity, mean age), geographical area, research design, clinical diagnosis-prevalence rate (outcome), diagnostic tool, interviewer, offence status, setting, quality score and main conclusions including study strengths and limitations. The lead author and co-author (AS) extracted relevant data for all included studies. Where there was disagreement, a third author would have been sought but no disagreement occurred. Excluded studies were inserted in a different form where reasons for exclusion were provided for those studies considered to be initially included.

Authors	Study year	Sample Size (N)	Setting	Age (Mean)	Sampling method	Country	Diagnostic Tool	Interviewer	Quality score
Abrantes	2005	252	Detention	16.3	consecutive	USA	PADDI	staff workers	8
Ajiboye	2009	53	Detention	17.3	referrals	Nigeria	MINI-KID	researchers	7
Andrade	2004	116	Parole	16.5	convenient	Brazil	KSADS-PL	psychiatrist	8
Ariga	2008	64	Detention	17.2	consecutive	Japan	MINI-KID (Jap.version)	researchers	8
Caufmann	1998	96	Detention	17.2	referrals	USA	PTSD module DSM-III-R criteria	psychologist	7
Dixon	2004	100	Detention	16.5	random	Australia	K-SADS-PL	psychologist	8
Duclos	1998	150	Detention	15	consecutive	USA	DISC-2.3, CIDI for PTSD	local lay interviewers	7
Eppright	1993	100	Detention	14.6	random	USA	DISC-Revised;SCID-II for personality disorders	psychiatrist	7
Gaete	2014	489	Detention	16.4	convenient	Chile	MINI-KID	psychologist	7
Gosden	2003	100	Detention	16.7	consecutive	Denmark	K-SADS-PL, SCID-II	psychiatrist	8
Gretton	2011	174	Detention	16.3	convenient	Canada	DISC-IV	psychology graduates	9
Harrington	2005	97	medium secure unit	14.8	consecutive	UK	K-SADS	researchers	7
Hayes	2013	30	Detention	14.9	consecutive	Ireland	DISC-IV;WAIS	researchers	6
Howard	2003	299	Detention	16.5	consecutive	Australia	self-report/structured questionnaire on self-harm & suicide attempts	researchers	7
Indig	2009	293	Detention	17	purposive	Australia	WAIS-IV FOR 17<, WISC-IV	psychologists	9
Karnik	2010	790	Detention	16.8	purposive	USA	SCID-IV DICA SIDP-IV for conduct disorder	researchers - clinicians	9

Kenny	2007	800	community-based orders	17	purposive	Australia	self-report/structured questionnaire on self-harm & suicide attempts	researchers	7
Kohler	2009	38	Detention	16	purposive	Germany	DSM-IV-->SCID-I;SCID-II	psychologists	7
Lader	1997	590	Detention	18	random	UK	PDs: (SCID-II), SCAN-->psychotic disorder;	Lay interviewers, psychiatrists-clinicians	9
Lederman	2004	493	Detention	15.2	consecutive	USA	DISC	independent non-detention staff	8
Lennox	2013	219	Detention	16.6	consecutive	UK	K-SADS	researcher	8
Plattner	2007	319	Detention	16.7	purposive	Austria	MINI-KID, MINI-KID suicidality mode	psychiatrists	8
Pliszka	2000	50	Detention	15.4	consecutive	USA	DISC 2.3	examiner	6
Rayner	2005	31	Detention	14	opportunistic	UK	K-SADS-E; WISC	researcher	6
Runchkin	2003	370	Detention	16.4	voluntary	Russia	K-SADS-PL	psychiatrists	8
Steiner	1997	85	Detention	16.6	referrals	USA	PTSD module DSM-III-R criteria	psychiatrist	7
Teplin	2002	1829	Detention		random	USA	DISC (2.3); DISC-IV (PTSD)	psychology students	8
Timmons	1997	50	Detention	15.8	random	USA	DISC	authors-researchers	6
Van Damme	2014	440	Detention	15.9	random	Belgium	DISC-IV	students	8
Vreugdenhil	2004	204	Detention	16.4	consecutive	Netherlands	DISC-C	DISC-trained research psychologists	8
Zhou	2014	232	Detention	16.8	opportunistic	China	K-SADS-PL	psychiatrist	9

5.10.3 Missing Data

Studies that involved mixed data (data not separated by gender) were not included except for one that included more than 90% boys (Pliszka *et al.,* 2000). Additionally, four studies included young individuals over 19 years (Cauffman *et al.,* 1998; Howard *et al.,* 2003; Karnik *et al.,* 2009; Plattner *et al.,* 2007); data were either included or excluded and a sensitivity analysis was performed to assess the overall impact on the conducted systematic review. Authors from two studies were contacted as the data were not separated by gender or they did not provide sufficient information about prevalence rates. The authors from the first study were keen to provide some missing data. However, the study was finally excluded as the dataset was in another language than English (Dias *et al.,* 2014). The authors from the second study did not respond resulting in the exclusion of the study (Garland *et al.,* 2001).

5.10.4 Sample and Study Characteristics

In total there were 8,953 participants (females=2,306, males=6,647) from 16 different countries: 10 studies from USA, 3 studies from Australia, 4 studies from the UK, 1 study from Ireland, 1 study from Nigeria, 1 study from Brazil, 1 study from Japan, 1 study from Chile, 1 study from Denmark, 1 study from Netherlands, 1 study from Belgium, 1 study from Germany, 1 study from Austria, 1 study from Russia, 1 study from Canada and 1 study from China. Sample sizes ranged from 30 to 1,829 participants and mean ages from 14.6 to 18 years.

Ten studies used DISC as their diagnostic tool, while the rest utilised a variety of tools such as K-SADS, PADDI, MINI-KID, and CIDI. Details about the study tools are shown in Table 2. Only three studies stratified their samples according to ethnicity. Other studies included the proportion of different ethnic groups without providing specific prevalence rates of mental disorders, thus we could not incorporate ethnicity into our statistical analysis. Lederman et al. (2004), stratified the sample according to first detention and more than one detention in a sample of 493 detained females.

The studies did not differ methodologically in setting and design; the participants in 28 studies were in detention and one was parole (Andrade *et al.,* 2004).

Unfortunately, only three studies had stratified their samples according to ethnicity (Indig *et al.,* 2009; Lader *et al.,* 1997;Teplin *et al.,* 2002). Other studies included the proportion of different ethnic groups without providing specific prevalence rates of mental disorders (Eppright *et al.,* 1993; Caufmann *et al.,* 1998; Steiner *et al.,* 1997; Dixon *et al.,* 2004; Harrington *et al.,* 2005; Lederman et al., 2004; Karnik *et al.,* 2009;Lennox *et al.,* 2013). Lederman *et al.*, (2004) stratified the sample according to first detention and more than one detention in a sample of 493 detained females. Prevalence rates did not substantially differ between the two groups. ODD was more prevalent in females with more than one detention (32%) compared to those who were detained for the first time (22%). Some other studies mention specific differences across ethnic groups.

Duclos *et al.,* (1998) collected data on prevalence of mental disorders across 150 American Indian youth both sexes. The majority of the sample had committed a status offence (e.g. truancy, curfew violation, alcohol consumption). Nearly half of the sample had a history of arrests. The results are consistent with those of other studies showing higher prevalence of internalising disorders among females; however, dysthymia was absent in males and females. Conduct disorder was much lower in this group than other ethnic groups in the current literature. Howard *et al.,* (2003) examined suicidal attempts across a large sample of Australian born and aboriginal and Torres Strait Islanders.

5.10.5 Meta-analysis results

Please refer to Table 7 for all meta-analysis results. The core paper presents summary forest plots rather than individual results for each mental disorder. Individual forest plots are available on the Appendices.

Table 5. Pooled prevalence of mental health problems displaying chi-square and I^2 heterogeneity measures

Diagnosis	Male prevalence with 95% CIs	χ^2 value for males	I^2value for males	Female prevalence with 95% CIs	χ^2 value for females	I^2values for females	Overall prevalence
Depression	17% (12%-21%)	706.29	97.17%	29% (19%-39%)	471.51	97.45%	21% (17%-24%)
Dysthymia	5% (2%-8%)	142.61	95%	22% (14%-31%)	33.4	88%	11% (7%-15%)
Manic Episodes	3% (1%-5%)	68.34	88.29%	5% (1%-8%)	22.10	81.90%	3% (2%-5%)
Self-harm	11% (7%-15)	18.38	83.68%	18% (5%-32%)	30.58	90.19%	13% (9%-18%)
Suicidal attempts	16% (12%-19%)	86.06	90.70%	27% (20%-34%)	37.33	81.25%	20% (16-25%)
Psychotic illness	6% (4%-8%)	153.81	92.20%	7% (3%-11%)	45.19	84.51%	6% (4%-7%)
PTSD	9% (6%-12%)	301.84	91.85%	27% (18%-35%)	110.49	94.70%	14% (11%-17%)
GAD	6% (4%-8%)	50.92	82.33%	9% (5%-13%)	60.02	86.67%	7% (5%-9%)
SAD	9% (6%-12%)	75.39	89.39%	26% (11%-40%)	195.56	97.95%	14% (10%-18%)
OCD	5% (3%-7%)	143.24	92.32%	7% (4%-10%)	26.46	65.99%	6% (4%-7%)
Phobia	4% (3%-6%)	9.58	16.50%	10% (4%-16%)	19.15	73.89%	5% (4%-7%)

Panic disorder	3% (2%-5%)	70.57	85.83%	7% (3%-10%)	30.27	80.18%	4% (2%-5%)
Conduct disorder	68% (56%-79%)	2363.17	99.15%	64% (45%-83%)	1282.65	99.06%	66% (56%-76%)
ODD	26% (20%-32%)	335.21	95.82%	28% (21%-35%)	117.65	91.50%	27% (22%-31%)
ADHD	19% (14%-24%)	334.79	94.92%	27% (16%-37%)	181.71	95.05%	22% (17%-26%)
BPD	15% (10%-21%)	34.42	85.47%	42% (35%-50%)	34.42	97.09%	21% (13%-28%)
ASPD	81% (69%-91%)	55.49	94.59%	32% (1%-94%)	216.95	99.08%	62% (39%-82%)
NPD	7% (6%-8%)	1.93	0.00%	8% (4%-14%)	.	0.00%	7% (6%-8%)
STPD	2% (1%-3%)	0.06	0.00%	2% (1%-6%)	.	0.00%	2% (1%-3%)
Borderline LD	33% (18%-47%	14.13	85.84%	26% (15%-41%)	.	0.00%	31% (20%-43%)
Mild LD	23% (12%-34%)	8.84	77.38%	5% (1%-17%)	.	0.00%	18% (8%-28%)

Depression Twenty-three studies reporting on depression are displayed on a forest plot. Overall prevalence was 21% (95% CI 17%-24%); 17% (95% CI 12%-21%) male offenders and 29% (95% CI 19%-39%) female offenders. Heterogeneity was significant across studies in males χ^2 value=706.29, p<0.001, I^2=97.17% and in females χ^2 value=471.51, p<0.001,I^2=97.45%. Gender and setting explained heterogeneity with p=0.04 (p<0.05), β=(1.13), SE(β)=0.061 and p=0.008 (p<0.01), β=-0.20, SE(β)=0.07 respectively.

Dysthymia Nine studies reporting on dysthymia are displayed on a forest plot. Overall prevalence was 11% (95% CI 7%-15%). Females had significantly higher prevalence rates than males; 22% (95% CI 14%-31%) females and 5% (95% CI 2%-8%) males were diagnosed with dysthymia. Heterogeneity was significant across studies in males χ^2=142.61, p<0.001,I^2=95% and in females χ^2=33.4,p<0.001,I^2=88%. On meta-regression for dysthymia, gender explained heterogeneity with p=0.001(p<0.01), β=0.17, SE(β)=0.04.

Manic episodes Ten studies reported on manic episodes. Overall prevalence was 3% (95% CI 2%-5%). The results showed that 3% (95% CI 1%-5%) males and 5% (95% CI 1%-8%) females presented with manic episodes and/or mania. Heterogeneity was quite significant in males with χ^2=68.34, p<0.001, I^2=88.29% and in females moderate to high with χ^2=22.10, p<0.001,I^2=81.90%.

Self-harm Three studies reporting on self-harming behaviours are displayed on a forest plot. Overall prevalence in both sexes was 13%(95% CI 9%-18%). The results clearly indicate that self-harm is more dominant among female offenders with 18% (95% CI 5%-32%) prevalence than among male offenders who present with 11% (95% CI 7%-15%) prevalence rate. Heterogeneity was significant across studies in males with

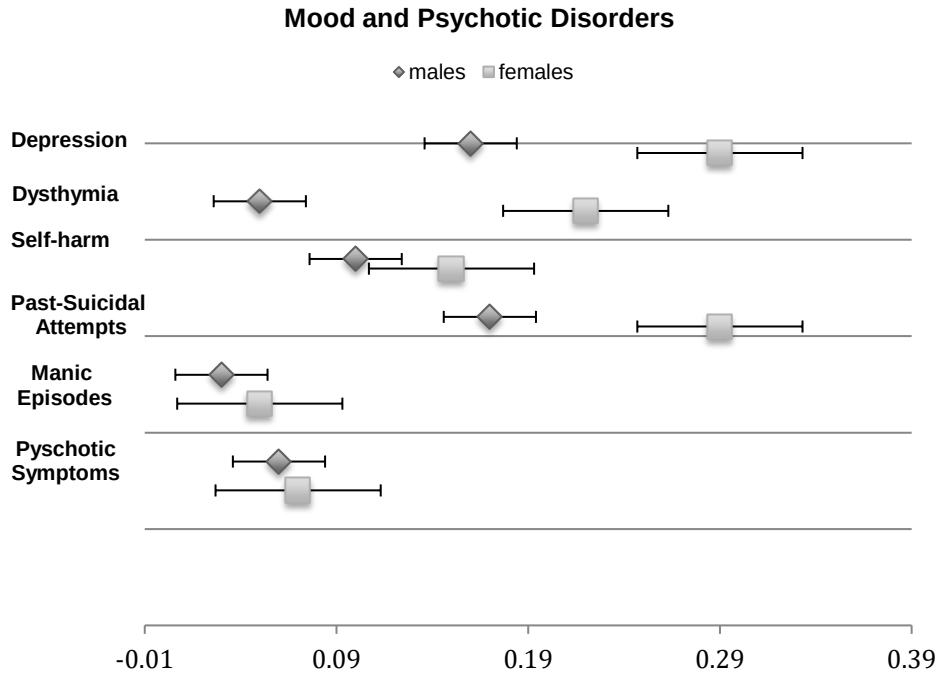
χ^2 value=18.38, p<0.001, I^2=83.68% and in females χ^2 value=30.58, p<0.001, I^2=90.19%.

Suicide behaviour Nine studies reported on suicidal behaviour and are displayed on a forest plot. Overall prevalence of past suicidal attempts was 20% (95% CI 16%-25%). According to the findings, 27% (95% CI 20%-34%) female offenders and 16% (95% CI 12%-19%) male offenders had attempted suicide at least once. Heterogeneity was moderate to high in males with χ^2 value=86.06, p<0.001, I^2=90.70% and in females χ^2 value=37.33, p<0.001, I^2=81.25%. Gender explains heterogeneity on meta-regression with p=0.03 (p<0.05), β=0.11, SE(β)=0.05.

Results from different ethnic groups could not be synthesized but they were looked at individually to infer conclusions. Abram et al., (2008) found that white groups had higher rates of suicide history compared to black and Hispanic ethnic groups while thoughts and concerns about death were more prevalent amongst African-Americans. Gallagher's (2006) study reported that black groups seem to be at higher risk of attempting suicide given the high suicidal ideation rates. The New South Wales Young People in Custody Health Survey showed that Aboriginal groups have a slightly higher rate of past suicidal attempts than Non-aboriginal groups (Indig *et al.,* 2009). Differences among ethnic groups could not be firmly established due to paucity of data.

Psychotic illness Fourteen studies assessed the prevalence of psychotic symptoms and/or disorder. There was no difference in prevalence rates between the two sexes, with 6% males (95% CI 4%-8%) and 7% females (95% CI 3%-11%) having psychotic illness. Heterogeneity was significant in males with χ^2=153.81,p<0.001,I^2=92.20% and less present in females with χ^2=45.19,p<0.001,I^2=84.51%.

Figure 7. Pooled prevalence figure on mood and psychotic disorders among young offenders



PTSD Nineteen studies reported on PTSD prevalence rates. Overall prevalence for both sexes was 14% (95% CI 11%-17%). Females had significantly higher PTSD prevalence 27% (95% CI 18%-35%) than males 9%(95% CI 6%-12%). Heterogeneity was significant among males and females with χ^2=301.84,p<0.001,I^2=94.70% and χ^2=110.49, p<0.001, I^2=91.85% respectively. For PTSD study size and gender explained heterogeneity in results. On meta-regression when controlling for study size p=0.03(p<0.05), β=0.15, SE(β)=0.06 gender had a significant p-value, as p=0.002 (p<0.01),β=0.17, SE(β)=0.05.

GAD Thirteen studies reported on GAD. Overall prevalence for the two genders was 7% (95% CI 5%-9%). Females had slightly higher GAD than males with prevalence rates of 9% (95% CI 5%-13%) and 6% (95% CI 4%-8%) respectively. Heterogeneity was moderate to high in males with

χ^2=50.92,p<0.001,I^2=82.33% and in females with χ^2=60.02, p<0.001, I^2=86.67%. Setting explained heterogeneity with p=0.049(p<0.5), β=-0.12, SE(β)=0.05.

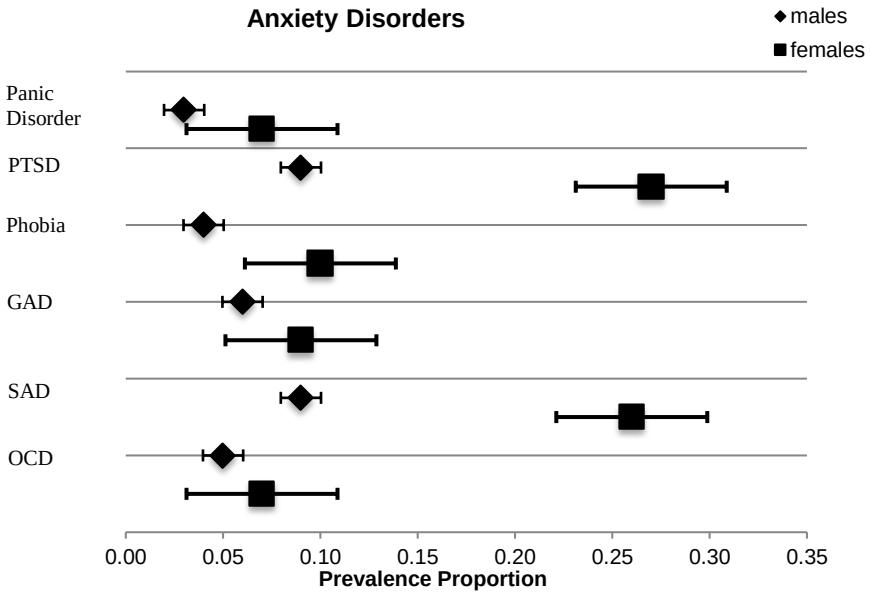
SAD Eleven studies reported SAD prevalence rates. Overall prevalence for both sexes was 14% (95% CI 10%-18%). Females had substantially higher prevalence than males and, specifically 26% (95% CI 11%-40%) females and 9% (95% CI 6%-12%) males were diagnosed with SAD. Heterogeneity was significant in males with χ^2=75.39 p<0.01 I^2=89.39% and in females with χ^2=195.56, p<0.001, I^2=97.95%. For separation anxiety disorder gender explained heterogeneity with p=0.033(p<0.05), β=0.15, SE(β)=0.06.

OCD Thirteen studies reported on OCD. Overall prevalence was 6% (95% CI 4%-7%). The results show that 5% (95% CI 3%-7%) male offenders and 7% (95% CI 4%-10%) female offenders qualify for OCD diagnosis. Heterogeneity was significant across studies whereas in males χ^2 value=143.24, p<0.001, I^2=92.32% and in females χ^2 value=26.46, p<0.001,I^2=65.99%.

Phobia Ten studies reported on phobia prevalence rates. Overall prevalence for both sexes was 5% (95% CI 4%-7%). Females had slightly higher phobia prevalence than boys with 10% (95% CI 4%-16%) and 4% (95% CI 3%-6%) respectively. Heterogeneity in males was non-significant with χ^2=9.58, p=0.30, I^2=16.50% and moderate in females with χ^2=19.15, p<0.001, I^2=73.89%.

Panic disorder Twelve studies were identified reporting on panic disorder. Overall prevalence was 4% (95% CI 2%-5%). Prevalence rates did not differ greatly between the 2 genders; males presented with 3% (95% CI 2%-5%) prevalence and females with 7% (95% CI 3%-10%). Heterogeneity was moderate to high in males with χ^2=70.57, p<0.001, I^2=85.83% and in females with χ^2=30.27, p<0.001, I^2=80.18%.

Figure 8. Pooled prevalence figure on anxiety disorders among young offenders



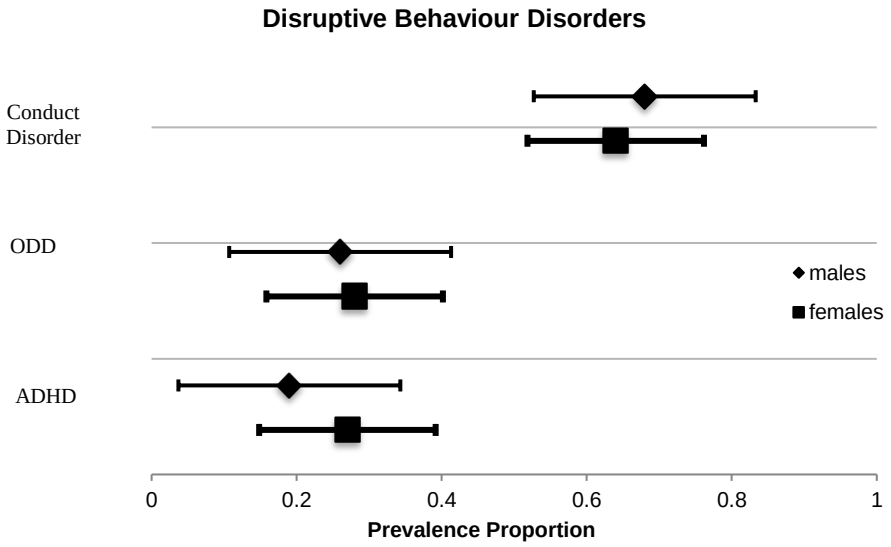
Conduct disorder Twenty-three studies reported on conduct disorder prevalence rates. Overall 66% young offenders (95% CI 56%-76%) were diagnosed with conduct disorder. Conduct disorder was present in 68% males (95% CI 56%-79%) and 64% females (95% CI 45%-83%). Heterogeneity was significant both in males and females with χ^2=2363.17, p<0.001,I^2=99.15% and χ^2=1282.65,p<0.001,I^2=99.06% respectively. Study size and prevalence type explained some heterogeneity in the results. On meta-regression when controlling for study size p=0.05,β=-0.22,SE(β)=0.10 and prevalence type p<0.05,β=0.1,SE (β)=0.04.

ODD Seventeen studies reported on ODD prevalence rates. Overall ODD prevalence was 27% (95% CI 22%-31%). The results showed that 26% (95% CI 20%-32%) males and 28% (95% CI 21%-35%) females were diagnosed with ODD. Heterogeneity was significant across studies in male

χ^2=335.21,p<0.001,I^2=95.82% and in female samples χ^2=117.65, p<0.001,I^2=91.50%.

ADHD Twenty-one studies reported on ADHD. Overall prevalence for both sexes was 22% (95% CI 17%-26%). Females had higher prevalence than males; 27% (95% CI 16%-37%) females and 19% (95% CI 14%-24%) males presented with ADHD. Heterogeneity was significant for both males and females with χ^2=334.79, p<0.001,I^2=94.92% and χ^2=181.71, p<0.001,I^2=95.05% respectively.

Figure 9. Pooled prevalence figure on disruptive behaviour disorders among young offenders

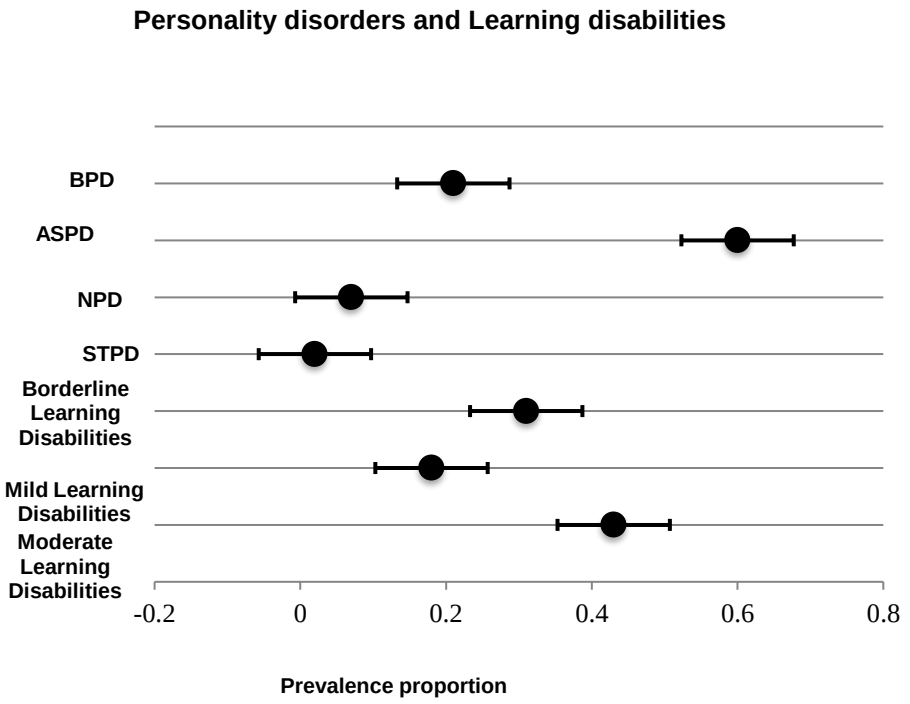


Personality disorders Overall prevalence for borderline personality disorder was 21% (95% CI 13%-28%). Heterogeneity was high with χ^2 value=84.61, p<0.001, I^2=91.73%. Studies reporting on APD included 1,418 participants out of those 1,137 qualified for an ASPD diagnosis. Overall prevalence for both sexes was as high as 62% (95% CI 39%-82%). Heterogeneity was significant with χ^2 value=367.08 p<0.001, I^2=98.37%.

Learning disabilities Studies reporting on borderline learning disabilities were identified with 145 out of 421 young offenders meeting the criteria for such a diagnosis. Overall prevalence for both sexes was 31% (95% CI

20%-43%). Heterogeneity was moderate with χ^2 value=15.42, p<0.001, I^2=80.55%. Seventy-six out of 421 young offenders presented with mild learning disabilities. Overall prevalence for males and females was 18% (95% CI 8%-28%). Heterogeneity was evident with χ^2 value=19.11, p<0.001, I^2=84.30%. Only one study reported on moderate learning disabilities whereas 291 out of 590 young offenders met the criteria for such a diagnosis. Overall prevalence for both sexes was 43% (95% CI 30%-56%). Heterogeneity was quite high with χ^2 value=27.94, p<0.001, I^2=89.26%.

Figure 10. Pooled prevalence figure on personality disorders and learning disabilities among young offenders



Overall (i.e. both sexes combined), the highest pooled prevalence rates were observed for ASPD, conduct disorder, and learning disabilities. Rates were lower for depression, BPD, ADHD, PTSD and suicidal behaviour. The lowest rates were observed for mania, psychotic illness, phobias and panic disorders, and narcissistic and schizotypal personality disorders. Females

had higher prevalence rates for depression, dysthymia, self-harm and suicide, PTSD, GAD, SAD, ADHD and BPD. Males had higher prevalence rates for conduct disorder and ASPD along with borderline, mild, and moderate Learning Disabilities.

5.9.6 Sub-group analysis and meta-regression results

Pooled prevalence rates for several mental health problems were not significantly heterogeneous (i.e., ODD, OCD, psychotic symptoms, self-harm, manic episodes and panic disorder). Therefore, we did not conduct meta-regressions for these mental disorders. We did not perform meta-regression analysis for personality disorders and learning disabilities due to the low number of studies (Higgins and Green, 2008).

We examined the influence of the moderating factors on the prevalence of depression, dysthymia, suicide attempts, PTSD, GAD, SAD, conduct disorder, and ADHD. There were only moderating effects for depression, PTSD, and conduct disorder. The moderating effects of the remaining disorders were not examined because there were less than nine studies (Higgins and Green, 2008). Supplementary meta-regression tables can be provided upon request.

Gender Female gender significantly positively moderated the pooled prevalence of depression (B=1.13, SE=0.06, $p<0.05$); dysthymia (B=0.17, SE=0.04, $p<0.01$); past suicide attempts (B=0.11, SE=0.05, $p<0.05$); PTSD (B=0.17, SE=0.05, $p<0.01$); and SAD (B=0.15, SE=0.06, $p<0.05$). Females had significantly higher prevalence of depression, past suicide attempts, PTSD and separation anxiety disorder.

Table 6. Multivariate meta-regression results on depression

Depression	B	SE	t	p-value	95% CI	
gender	0.27	0.11	2.48	0.07	-0.03	0.57
setting	-0.50	0.11	-4.70	0.01**	-0.79	-0.20
sample size	0.01	0.09	0.14	0.10	-0.23	0.26
age	-0.01	0.07	-0.18	0.87	-0.20	0.17
trial status	0.01	0.08	0.10	0.93	-0.22	0.23
prevalence time frame	-0.10	0.03	-0.31	0.77	-0.09	-0.07
study quality	-0.77	0.07	-1.09	0.34	-0.27	0.12
cons	0.37	0.46	0.79	0.48	-0.92	1.66

Number of obs =12, tau2 = .01, I-squared_res = 93.75%, Adj R-squared = 74.34%,Model F(7,4) = 4.65, Prob > F = 0.0782

gender entered as dummy (male vs. female) ref is male

setting entered as dummy (detention vs. non-detention) ref is detention

sample size entered as dummy (small. large) ref is small

age entered as dummy (young vs. old) ref is >16 years

trial status entered as dummy (pretrial vs. post-trial) ref is pre-trial

prevalence time frame entered as continuous (point, period, lifetime prevalence)

study quality entered as dummy (low vs.high) ref low<6

Setting Detention setting significantly negatively moderated the prevalence of depression (B= -0.20, SE=0.07, p<0.01) and GAD (B= -0.12, SE=0.05, p<0.05). Those in detention had significantly lower prevalence rates of depression and GAD than those in non-detention.

Sampe size Small sample size significantly negatively moderated the prevalence of PTSD (B=-0.26, SE=0.07, p<0.05) and conduct disorder (B= -0.22, SE=0.10, p<0.05). PTSD and conduct disorder were less prevalent in large sample studies (i.e., more than 100 participants) than smaller sample size studies.

Table 7. Multivariate meta-regression results on PTSD

PTSD	B	SE	t	p-value	95% CI	
gender	0.22	0.06	3.83	0.02*	0.06	0.39
sample size	-0.26	0.07	-3.89	0.02*	-0.44	-0.07
age	-0.05	0.06	0.94	0.40	-0.21	0.10
trial status	0.09	0.06	1.66	0.17	-0.06	0.25
prevalence time frame	-0.04	0.02	-1.65	0.17	-0.11	0.03
study quality	0.07	0.06	1.26	0.28	-0.09	-0.23
cons	-0.18	0.30	-0.59	0.58	-1.01	0.66

Number of obs =11, tau2 = .003148, I-squared_res = 92.29%, Adj R-squared = 84.10%, Model F(6,4) = 7.24, Prob > F = 0.0380 note: Setting dropped because of collinearity

gender entered as dummy (male vs. female) ref is male

sample size entered as dummy (small. large) ref is small

age entered as dummy (young vs. old) ref is >16 years

trial status entered as dummy (pretrial vs. post-trial) ref is pre-trial

prevalence time frame entered as continuous (point, period, lifetime prevalence)

study quality entered as dummy (low vs. high) ref low<6

Study quality Study quality significantly positively moderated the prevalence of conduct disorder (B=0.10, SE=0.18, p< 0.05) when we controlled for the other moderators (gender, setting, sample size, age). Conduct disorder was more prevalent in lower quality studies (i.e., less than 7 quality square) than higher quality studies.

Table 8. Multivariate meta-regression results on conduct disorder

Conduct disorder	B	SE	t	p-value	95% CI	
gender	0.31	0.26	1.21	0.28	-0.04	0.98
setting	0.15	0.17	0.87	0.42	-0.30	0.60
sample size	-0.62	0.30	-2.83	0.04*	-1.19	-0.06
age	-0.21	0.17	-1.20	0.28	-0.66	0.24
trial status	0.26	0.16	1.65	0.16	-0.15	0.67
prevalence time frame	0.04	0.07	0.56	0.60	-0.13	0.21
study quality	0.50	0.18	2.78	0.04*	0.04	0.96
cons	-0.68	0.74	-0.92	0.40	-2.59	1.23

Number of obs =13, tau2 = 0.04, I-squared_res = 98.34%, Adj R-squared = 46.34%, Model F(7,5) = 2.43, Prob > F = 0.17

gender entered as dummy (male vs. female) ref is male

setting entered as dummy (detention vs. non-detention) ref is detention

sample size entered as dummy (small. large) ref is small

age entered as dummy (young vs. old) ref is >16 years

trial status entered as dummy (pretrial vs. post-trial) ref is pre-trial

prevalence time frame entered as continuous (point, period, lifetime prevalence)

study quality entered as dummy (low vs.high) ref low<6

5.11 Discussion

In the current review, I synthesised the prevalence rates of psychiatric disorders, mental health problems, past suicide attempts and learning disabilities among young offenders. I will discuss these findings in particular, as these disorders have been relatively neglected in the extant youth offender literature.

5.11.1 Meta-analysis results

ASPD was the most common disorder among young male offenders, with a pooled prevalence of 81%. The high rates of ASPD traits are consistent with previous reviews of prison populations. However, this review found higher ASPD rates in both sexes. Fazel and Danesh (2002), for example, found that 65% male and 21% female offenders presented with ASPD. In this review 35% young female offenders presented with ASPD. Overall more than half of the participants met the clinical criteria for ASPD. This highlights the need for the appropriate identification and treatment of this disorder in this population. Indeed, studies suggest that young male offenders presenting with antisocial or psychopathic features who receive intensive treatment, e.g., multi-systemic treatment (MST) are less likely to reoffend (Caldwell *et al.,* 2006; Utting *et al.,* 2007). There were only a limited number of studies examining ASPD in young offenders, and there were few prospective studies looking at the criminal trajectory of young offenders with psychopathic traits. These studies particularly addressed that whilst we cannot diagnose ASPD before 18 years, they examined whether this group presented with ASPD traits earlier (Timmons-Mitchell *et al.,* 1993). Future studies may consider the extent to which antisocial traits precede or follow offending behaviour (Winsper *et al.,* 2013).

The pooled prevalence of borderline personality disorder (BPD) was 21%. More female offenders (42%) presented with BPD symptoms than male offenders (15%). This gender pattern is largely consistent with the adult and adolescent literature (Black *et al.,* 2007; Hill *et al.,* 2014), though there are suggestions that rates in male offenders may be higher than previously thought (Grant *et al.,* 2008), thus indicating that BPD should not be overlooked in male populations (Black *et al.* 2007). Studies suggest that offenders with BPD have an increased risk of reoffending compared to offenders without BPD, and that BPD in offenders is associated with substantial psychological stress and impaired quality of life (Black *et al.* 2007). This highlights the need for correctional facilities to improve their screening and treatment for BPD, particularly in young people for whom

early symptoms of the disorder is often under-recognised (Winsper *et al.* 2015).

Congruent with previous reports, the pooled prevalence of learning disabilities was high in our review (Talbot and Riley 2007). A review including adolescent and adult offenders found that 39% had some kind of learning difficulty or disability; we found an even higher pooled rate of 51% (moderate IQ scores) in youth only populations. Learning difficulties have been linked to antisocial behaviour and also to ADHD (Penner *et al.,* 2011). An interesting area for future work would be to examine whether being socially marginalised and excluded from school in those young people with learning disabilities could escalate into more serious delinquent behaviour, as previous studies have reported that delinquent behaviour might be linked to school exclusion (Chitsabesan and Bailey, 2006).

Attempted suicide rates were much higher (i.e., 3 times greater) than rates in the community. Thus, suicide risk is a major concern for young offenders in custody (Moore *et al.,* 2015). Prior research suggests that suicide attempts rise once young people are admitted to custodial settings. The risk for suicidal behaviour could be related to ongoing mental health problems, but also attributable to being incarcerated and exposed to bullying and other stressors (Lambie and Radell 2013). More regular screening for young people presenting with risk factors should take place to reduce the risk of suicide attempts (Bhatta *et al.,* 2014). Further, alternatives to detention such as community-based programmes should be considered where possible (Lambie and Radell, 2013).

The results of the current review diverge slightly from those of Fazel's et al. (2007) and Colin's et al. (2010) reviews. We found a higher pooled prevalence of conduct disorder especially in young female offenders. The pooled prevalence for males was 68% and for females 66%, while Fazel found a prevalence of 52.8% for both sexes. Colins who examined CD in males only reported a prevalence of 46.4%. The reasons for the higher prevalence in our review are unclear and may reflect changes in diagnostic

criteria, methodological variations across studies, or a genuine increase in CD rates (Singh and Winsper, 2017).

Unsurprisingly, depression was found to be higher among females than males, as previous studies have shown (Chitsabesan *et al.,* 2006; Fazel *et al.,* 2008). Female adolescents have an increasingly high risk of being diagnosed with depression and young female offenders fall under the same umbrella with the general population (Thapar *et al.,* 2012). Depression is associated with aggressive behaviour in delinquent youth whereas in the literature it has been described as “irritable mood” and depression is considered a precursor of anger (Grisso, 2004).

Gender differences in dysthymia rates were quite evident and as it could be predicted, female young offenders had significantly higher rates of dysthymia than male young offenders. Depression has become a female characteristic in young populations after reaching 12 to 14 years; one study on young adolescents showed that dysthymic disorder was twice as common among girls than boys (Bennett *et al.,* 2005). The literature findings are consistent with this meta-analysis that found female young offenders were almost five times more likely than male young offenders to meet the criteria for dysthymia diagnosis. Early detection of dysthymia among adolescents can turn out crucial since if left untreated there is a high likelihood that the young person moves onto major depression; the earlier the onset of dysthymic disorder, the poorer the outcomes of recovery are (Masi *et al.,* 2001). Masi and colleagues examined solely dysthymic disorder in a group of children and adolescents and looked at the specific symptomatology of the disorder. Their results highlighted the importance for early intervention as 44% of these young individuals had suicidal thoughts. In the context of the criminal justice system and young offenders, dysthymic disorder, which is a chronic disease, can become an additional burden for this particular group and along with the restrictive environment of a secure setting might increase suicidal ideation.

The current literature has attempted to establish a relationship between depression and criminal behaviour but results cannot be seen as robust since other explanations are offered as the cause of criminal behaviour and such a causal relationship cannot be proved (Anderson *et al.,* 2012). Accordingly, engaging in delinquent behaviour during adolescence might predict the emergence of depression later on and criminal behaviour is considered to result in depression psychopathology (Siennick, 2007). Depression seems to be a risk factor for females and increases the likelihood of engaging in criminal behaviour; the same study found that a history of criminal arrests makes men more prone to depression and in general, individuals who suffer from depression are more likely to be involved in crimes (Thompson, 2008).

The Ministry of Justice (2015) admits that young offenders between18 and 24 years are in high risk for suicide and the number of 83 suicides has quite escalated since 2013. After carrying out sensitivity analysis the results did not really change along with the overall prevalence of past suicidal attempts that is nearly 20% amongst both sexes. Conducting a sensitivity analysis for self-harming was not deemed necessary, as only a few studies were included in the forest plot. According to Stokes' review (2015) on suicidality, suicidal history varied up to 21% amongst detained young offenders that coincides with this meta-analysis's findings. Some studies showed than about 50% of young offenders in detention would attempt suicide (Stokes *et al.,* 2015). Results from different ethnic groups could not be synthesized but they were looked individually to infer conclusions. Abram et al., (2008) found that white groups have higher rates of suicide history compared to black and Hispanic ethnic groups while thoughts and concerns about death were more prevalent amongst African-Americans; this finding could be connected to Gallagher's (2006) study reporting that black groups seem to be at higher risk of attempting suicide. The New South Wales Young People in Custody Health Survey showed that Aboriginal groups have a slight higher rate of past suicidal attempts than Non-aboriginal groups (Indig e*t al.,* 2009). Dixon and colleagues (2004) also mention that Aboriginals had more suicidal attempts on their

records than non-Aboriginal groups. It looks there are some differences among ethnic groups but the paucity of cumulative results does not allow conclusive inferences.

The results of this review showed that anxiety disorders are quite common among young offenders consistent with previous reviews (Colins *et al.,* 2010). SAD was higher among females than males and overall prevalence was significant at 14%. The results were similar to Colin's review where overall prevalence was about 11%. Interestingly enough, SAD was higher among females than males and overall prevalence was significant at 14%. The current literature highlights that separation anxiety rates among young offenders might escalate during their transfer to institutional settings. Young inmates have to leave their home and friends (Abram *et al.,*2008) to move to a restricted environment where their needs are confined. For GAD geographical location might be important with higher prevalence rates in non-western countries; though the results were not statistically significant and not in line with the literature that poses western cultures in higher risk for developing generalised anxiety disorder than non-European cultures (Lewis- Fernández *et al.,* 2010).

The lower rates of psychosis might be explained with the fact that psychotic episodes do not become present until early twenties and the included population is younger (Hill *et al.,* 2015). Males tend to have higher prevalence rates of psychotic illness than females; however, in this study prevalence rates were similar. The results are consistent with previous research whereas nearly 3% females and males presented with psychotic illness (Fazel *et al.,* 2008). In this study psychotic symptoms were quite higher presumably due to the different category-psychotic symptoms comprise a broader category. Yet after conducting an influence-sensitivity analysis and outlier-studies were omitted the results were modified; psychotic symptoms were prevalent in 3% females and 4% males.

It is not unusual for young offenders to carry a history of traumatic events in their past either physical or sexual abuse and, young females, especially,

compose an emotionally fragile and distinct group in the prison system, whereas their traumatic past has been linked to the manifestation of violent symptoms and, consequently to offending (Moore *et al.,* 2013). Moore and colleagues delineated a cohort of young offenders in New South Wales and reported that females had much higher PTSD rates and, specifically 40% and 17% respectively. The authors indicate that females tended to report on child abuse and neglect more frequently than males (Moore *et al.,* 2013). However, this difference could be explained by gender disparities, as males might carry feelings of shame and be more reluctant to report on childhood sexual abuse. In this review, the results showed similar discrepancy between males and females PTSD rates with females far outweighing males. Fitzgerald et al. (2012) assert that adverse childhood experiences can shape the criminal career of offenders; there is a relationship between severe offending and childhood abuse. This finding is critically significant for future research in order to distinguish female offenders and understand to a more sufficient extent the reasons lying behind their aggressive behaviour and also improve intervention models that aim to treat PTSD symptoms.

Conduct disorder generated similar prevalence rates between males and females congruent with previous findings (Fazel *et al.,* 2008). Non-DISC tools elicited higher prevalence rates than DISC, and this might be consistent with the assertion that DISC might underestimate prevalence of conduct disorder among young individuals (Fazel *et al.,* 2008). A diagnosis of conduct disorder, before the age of 15 years, along with schizophrenia might lead to aggressive behaviour in the future and increases the risk of offending for both males and females (Hodgins *et al.,* 2008). Conduct disorder is quite prevalent among youth in contact with the criminal justice system and there has been a debate as to whether it composes a disorder or not. A clear link between conduct disorder and criminal behaviour cannot be made but comorbidity with other mental health disorders such ADHD, ODD, PTSD might establish a stronger relationship with violent behaviour (Grisso, 2004). The high rates of conduct disorder in young female

offenders should be also highlighted. This group of female offenders may present with higher psychopathic traits and be more resistant to treatment. Research has shown that callous unemotional traits are highly correlated with delinquent behaviour and aggression among female offenders. Wasserman et al. (2005) emphasises that girls with conduct disorder have more severe psychopathology than boys.

The results on ADHD prevalence in this meta-analysis showed that females have higher rates (27%) than males (19%) in line with Fazel's review whereas boys had 11.7% and girls had 18.5% ADHD rates. Inflated results might derive from over-diagnosis and reliability on self-reports. Though the relevant literature poses males in higher risk for ADHD than females (Young *et al.,* 2011). In any case there is a link between ADHD and criminal behaviour that seems to be explained by impulsivity and mood fluctuation that are the basic features of the disorder.

5.11.2 Meta-regression results

Gender was a significant moderator of the pooled prevalence of depression, dysthymia, past suicidal attempts, PTSD and SAD, indicating that these disorders are significantly more common in females. Of these disorders, Fazel and Danesh (2002) only examined depression, and similarly found that gender accounted for heterogeneity in prevalence rates. The higher prevalence of PTSD and suicide attempts in females is consistent with the literature outside of offender populations (Tekin *et al.,* 2016). PTSD is highly co-morbid with BPD in youths (Winsper *et al.,* 2016). It is plausible that some female offenders have a constellation of symptoms: BPD, PTSD, suicide attempts, dysthymia, which are associated with previous exposure to trauma (Winsper *et al.,* 2016). These, in turn, may increase risk of offending (Moore *et al.,* 2013), though they could also result from being incarcerated. Future prospective studies may examine these links.

It was expected that DISC would yield different rates than other tools and in the case of depression prevalence rates were lower than other diagnostic

instruments. Yet the prevalence rate differences between DISC and other diagnostic tools are not substantially or statistically significant. Additionally, the slight difference between larger and smaller size studies could be explained by size effect and sample power. In this case though it would be expected that smaller studies would yield higher prevalence rates due to smaller sample size; however, in depression rates the opposite effect occurred.

5.12 Limitations and Future Research

When considering the results of our review, it is important to consider certain limitations. First, it was not possible to look at the prevalence of mental health problems across various ethnic groups as there wereenough studies reporting prevalence rates according to ethnicity. Future studies could include different ethnic groups to allow comparisons in prevalence rates and address the needs of these groups.

Second, we could not compute comorbid mental health problems due to missing information from the included studies. This group of young people presents with complex and multiple needs and mental health problems overlooked by the current literature. Justice-involved youth in various settings such as secure hospitals and community placements have a number of mental health problems and symptoms that seem to be the most difficult to treat (Hill et al., 2014). There were not enough studies to examine comorbid mental health difficulties. However, this was not in the scope of this study. This meta-analysis comprised a robust methodology that synthesised quantitatively all methodologically high-quality prevalence studies. Meta-analysis is traditionally used in health and medical research to understand the effectiveness of interventions and randomised controlled trials. However, epidemiological research has used meta-analytic studies to understand prevalence phenomena more efficiently. Therefore, epidemiological studies do not include intervention models and causal relationships. This study looked at the prevalence of mental disorders in detention settings and the main limitation was the lack of available studies

across different forensic settings other than prisons. Yet, a majority of these young people transition throughout several settings within and across the youth justice system and this meta-analysis captures this group in the findings.

Third, this review excluded substance abuse problems and, therefore the results are not entirely representative. Substance abuse is significantly high in prisons and concurs with other mental health problems. However, it is likely that substance abuse rates among young offenders are not accurate due to access to substances in prison settings and response bias (Fazel et al., 2008). Fourth, the number of studies including emerging PDs and LDs was low limiting the reliability of estimated rates and forest plots might display inflated rates. Last, we included studies that used the Weschler criteria focusing on reading comprehension, reasoning and working memory to measure LDs that might not apply to the various international contexts (Gomez, Vance, & Watson, 2016).

Finally, index offences could not be explored due to lack of information. It would be informative to study the relationship between violent versus non-violent offences and the nature of mental disorders to establish whether more serious mental illness is linked to more violent behaviours. There are some notions in the literature that certain disorders might be associated with more severe crimes and empirical information would add important knowledge. For instance, ASPD and a history of conduct disorder along with schizophrenia have been linked with violent crime and, specifically schizophrenic patients with antisocial traits are in higher risk of engaging in criminal and violent behaviour (Maghsoodloo *et al.,* 2012).

5.13 Publication bias

It was assumed that publication bias tests (funnel plots) were not necessary for this type of meta-analysis. Publication bias concern primarily studies including interventions while prevalence studies seem more resistant to authors' publication bias. In small sample studies it was

expected that the standard error will be large and the confidence intervals wider along with high p-values.

Since this study belongs to observational systematic reviews and meta-analyses funnel plots would not be the appropriate mode to explore heterogeneity and assess publication bias. Thus, sensitivity analysis was selected as a proper method to examine publication bias taking into account heterogeneity in prevalence rates between studies either overall or by gender. Sensitivity analysis was conducted in order to find whether the inclusion or exclusion of certain studies that acted as outliers influence the results (Higgins, 2012).

However, as some scholars would argue including solely peer-reviewed studies might add publication bias manifesting in effect sizes. This meta-analysis although was primarily descriptive looking at mental health problems' prevalence rates (Ohayon *et al.,* 2004).

5.14 Conclusions

As the findings from this review suggest, the youth justice system and mental health services within should work together to adopt an interdisciplinary person-centred approach targeting incarcerated youth (Underwood and Washington, 2016). By addressing the complex needs of these youth, we can move a step nearer to rehabilitation and providing community alternatives to the more traumatized groups through education and recovery programmes.

Emerging PDs were highly prevalent in both sexes. As research suggests PDs are predictors of reoffending, these need to be adequately treated in younger populations (Coid, 2003). Offending behaviour tends to decline with age whilst adolescence is a risk period for delinquent behaviour, where interventions should target this group. Investing in empirically supported intervention strategies has the potential to interrupt the criminal trajectory associated with emerging PDs (Vizard, 2008; Young *et al.,* 2015). Future research should be directed to the detection of more types of PDs such as paranoid personality disorder. Lader et al (2003) found that emerging

paranoid personality disorder was the second most prevalent mental health concern amongst young offenders in the UK. Earlier recognition of emerging PDs would accelerate treatment and also reinforce strategies such as Psychologically Informed Planned Environments initiated in the UK to reduce destructive behaviours among adult offenders with PDs (Turley *et al.,* 2013).

LDs were also common in this sample, and the research literature suggests a link between LDs and reoffending (Talbot and Riley, 2007). Studies have been using IQ-cut off scores to detect LDs (O'Brien, 2001). Offenders with LDs may lack understanding of their detention and can become victims of bullying (Talbot and Riley, 2007). Exacerbating these problems, specialist services, such as mental health-in reach, are often not available (Chitsabesan *et al.,* 2006). Consequently, offenders with LDs may be at high risk of reoffending and developing further behavioural problems (Cortiella and Horowitz, 2014). Therefore, it is necessary to invest more in education for young individuals whilst in prison and more importantly when they return to the community (Cortiella and Horowitz, 2014). Youth with such complex needs should be diverted from the youth justice system and re-integrated into structured community programmes aiming to rehabilitation and recovery (Underwood & Washington, 2016). As of now, young people with LDs are more likely to experience school exclusion and be in contact with the youth justice system (Cortiella and Horowitz, 2014).

Young female offenders present with an atypical pattern of psychopathology (in comparison to community populations) that needs further investigation, such as high CD and ASPD rates. Future research should focus on disorders that are traditionally more common in males including CD, ADHD and ASPD. Mental health services for detained young people presenting with emerging personality disorder symptoms should design effective care pathways (Hill *et al.,* 2014) addressing past trauma and insecure attachment styles to interrupt the psychopathology and reduce the risk of reoffending. This should be achieved by offering developmentally-driven training to staff members and healthcare professionals involved in young people's care and also providing community and school programmes for the most susceptible youth identified

as high risk (Coid, 2003). In order to improve current prevention and intervention services for youth with emerging PDs, we need to account for present and past factors in young people's lives to change policy and clinical practice. The next chapter will address Phase 2 of the research study, which is the mapping exercise that identifies young people accommodated in forensic inpatient units across England in transition of care to adult mental health services and community settings.

6 Mapping transitional care-pathways among young people discharged from forensic child and adolescent mental health services

"The day before he hanged himself, he told his mother he would make a suicide attempt to force the authorities to move him from prison to a children's home."

(Willow, 2015: 51)

6.1 Chapter overview

This chapter presents Phase 2 of the research study that is a mapping exercise of young people transitioning from six national inpatient forensic child and adolescent mental health services in England. This chapter aimed to examine the transition policies, processes and practices of FCAMHS. All young people close or those who have reached the transition age boundary based on the national standards (18 years) between May 2016 and November 2016 were included.

6.2 Research Question:

What are the transition policies, processes and practices of FCAMHS for young offenders in secure adolescent units in England?

6.2.1 Aims

The aims of Phase 2 of the research study were:

- to determine the number of young people transferring from forensic child services (annually and within six months to establish the team's caseload);
- to establish the age transition boundary across forensic child mental health services;
- to examine demographics (ethnicity and age), diagnosis, index offence, legal status, and discharge destination for this cohort;

- to determine on policy, guidelines and protocols for transitions across forensic adolescent inpatient units;
- to examine transition preparation and management to look at commonalities and differences in transition process across hospitals;
- to look at time from referral date to discharge date (waiting time) to determine whether transition delays occurred throughout services.

All national services funded by the National Commissioning Group (NCG) in London, Southampton, Northampton, Birmingham, Manchester and Newcastle were included. Ethical approval was received from the South Birmingham Ethics Committee in January 2016.

Currently, there are 70 beds available across all six nationally commissioned units. They admit young people between 12 and 18 years. Some units have additional beds available for occupancy, but these are not NHS funded. Two secure units are specialised in young people with learning disabilities and one unit in neurodevelopmental disorders.

6.3 Results

The results on staffing levels, demographics, diagnosis, index offence, legal status transition preparation and discharge destination are summarised in tables and figures. The results of the open-ended question regarding transition preparation are displayed on Table 6. All respondents described in text the services they represented, as FCAMHS and national services. Five local collaborators were consultant forensic child and adolescent psychiatrists and one was consultant clinical forensic psychologist.

6.3.1 Staffing levels

Staff specialist numbers varied across hospitals; however, all national services offered a range of activities through art therapy or occupational therapy. One ward did not have an occupational therapist and none of the

units had a primary mental health practitioner or psychodynamic psychotherapist. Two hospitals did not have a family therapist.

6.3.2 Demographics

Thirty-four patients were eligible for transfer and referred to adult services and community within May 2016 and November 2016. This cohort included 71% males and 29% females. The sample consisted of 65% White British and 9% other white ethnic groups. Only 15% were Black and the remaining 11% were from mixed and South Asian backgrounds.

6.3.3 Number of referrals

The average numbers of referrals to all services during last calendar year (June 1st 2016 to May 31st 2016) was 11.17 (*SD*=3.43, *Mdn*= 9.5) among the six hospitals. The mean number of current open cases at the time was 9.17 (*SD*=3.92, *Mdn*=9). The average number of accepted referral cases to adult services per year over the last three years among the six services was 9.92 (*SD*=9.1, *Mdn*=6.5).

Table 9. Number of referrals from FCAMHS to adult and community services between May 2016 to November 2016

Medium secure unit	Number of referrals for transitions for May 2016-Nov 2016
Hospital 1	6
Hospital 2	9
Hospital 3	6
Hospital 3	2
Hospital 5	5
Hospital 6	6

6.3.4 Age transition boundary

Age boundary was consistent across all hospitals, defined the age limit as being 18 years. However, they were allowed to keep patients until their 19th birthday (Dent *et al.,* 2013). One clinician stated that if the patient can be treated in hospital until their 19th birthday, then, they are allowed to keep them to avoid additional transitions. Young people cannot stay beyond their 19th birthday and a new adult placement has to be identified. Also they do not refer patients if they have reached the age transition boundary of 18 years and the remaining treatment is two to three months-they stay in the unit. However, if longer treatment is necessary, then, the patient is referred to adult services. One clinician mentioned that patients are referred before they turn 18 years to leave child services.

One psychiatrist mentioned:

"The CQC registration allows us to keep patients over the age of 18 and our nationally agreed admission criteria allows us to keep patients to 18.5 (or up to 19 with commissioner approval) if there is an appropriate reason (e.g. they are in the process of making a transition directly into a community service). Because many of our patients have had fragmented care histories and/or ASD we try where possible to minimise transitions and achieve a single move to a highly structured community service with an appropriate legal framework like Guardianship or a CTO with or without DOLS."

A third clinician said:

"We keep patients until 19 years if they can benefit from staying."

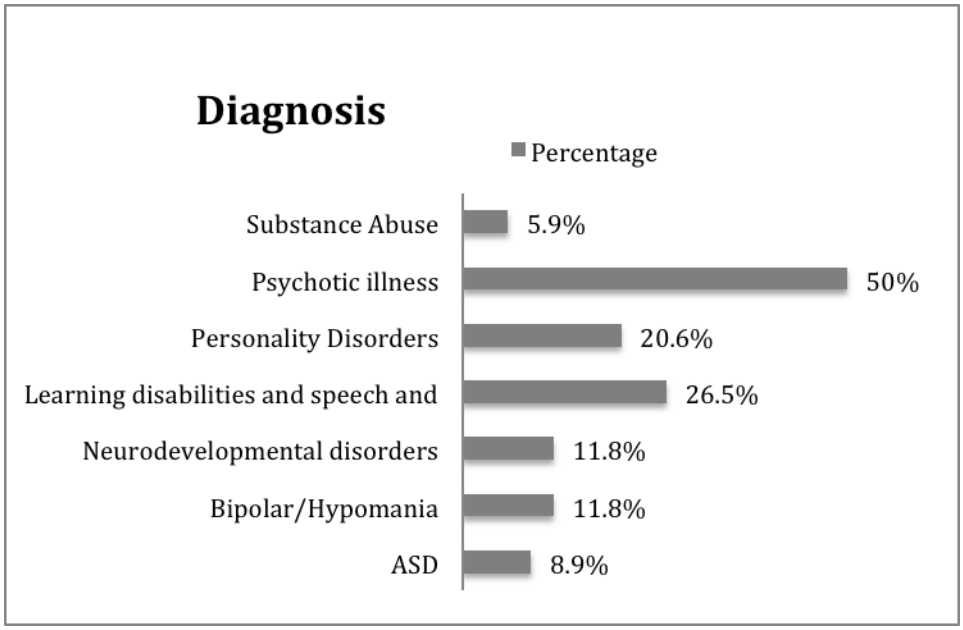
Another clinician stated:

"Adult services only accept 18 and up and we have to transfer by 19th birthday."

6.3.5 Diagnosis

Half of the participants had a schizophrenia spectrum disorder including psychosis, schizoaffective disorder and schizophrenia. Ten patients had psychosis from those two presented with a first episode psychosis. Five patients were diagnosed with schizophrenia and two with schizoaffective disorder. Two of the forensic child and adolescent hospitals are specialised in populations with learning disabilities (LD) and autistic spectrum disorders (ASD). Accordingly, LD (23.53%) and ASD (23.53%) were quite high in the group. One young person had borderline LD and another patient had mild to moderate LD, whilst the remaining had mild LD. Conduct disorder was nearly 21% prevalent among this group. Overall, comorbidity of mental disorders, learning disabilities and neurodevelopmental disorders was common. Fifteen patients had more than one mental health problem. Of those, seven had two mental health problems and eight had more than two mental health problems including learning disabilities.

Figure 11. Diagnosis among young people in FCAMHS



6.3.6 Index offence-MHA

A majority of the patients had assaulted a member of the public or staff and were sectioned under part III of the Mental Health Act (MHA). Robbery was the second most common offence followed by low rates of murder, rape, and arson. Young people under sections 47/49 and 48/49 of the MHA were

prison transfers either sentenced or on remand. Those under sections 37 and 28 were hospital orders by the court.

Table 10. Demographics and characteristics of young people in FCAMHS

Demographics	Frequency (N=34)	Percentage (%)
Age during 6-month period		
17.5 years	6	17.7
18 years	25	73.5
19 years	3	8.8
Gender		
Males	24	70.6
Females	10	29.4
Ethnicity		
White British	22	64.7
Black	5	14.7
Mixed	2	5.9
White Other	3	8.9
South Asian	2	5.9
Offence		
Assault on public member or staff	19	55.9
High risk/no offence	3	8.8
GBH	1	2.9
Arson	1	2.9
Murder	2	5.9
Rape	1	2.9
Theft	1	2.9
Robbery	5	14.7
Burglary	1	2.9
Violence/Aggression	1	2.9
Sexualised behaviour	2	5.9
MHA		
Section 3	20	58.8
Section 37	5	14.7
Section 47/49	5	14.7
Section 48/49	2	5.8
Section 37/41	1	2.9
Section 38	1	2.9

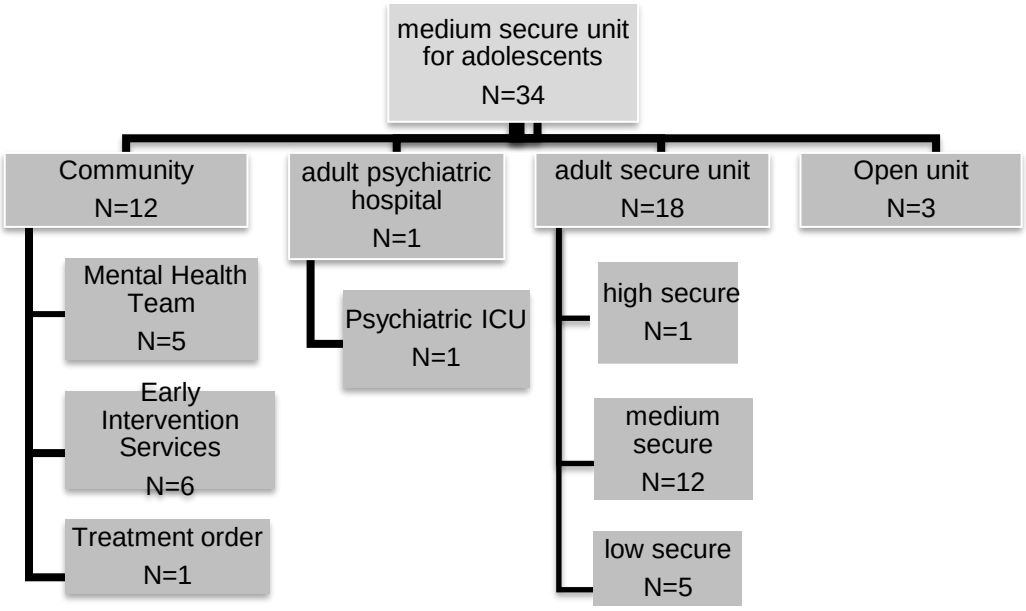
6.3.7 Transition delays

The average discharge waiting time –from the time of referral to adult service to discharge date- for 29 patients was eight months including nine patients waiting between nine to thirteen months. Three patients were referred to adult services from the point of admission and the precise waiting time could not be estimated. Two patients had not moved to adult services by the study's end date.

6.3.8 Transition destination

All hospitals reported that they collaborate with several adult services and agencies such as the criminal justice system, community mental health teams, forensic services, early intervention services (EIS) and learning disability services. Majority moved to medium secure hospitals whilst one patient was transferred to a high secure hospital and three stepped down to low secure hospitals.

Figure 12. Transition destinations among 34 young people discharged from FCAMHS



6.3.9 Protocol policy-staff grade/differences-commonalities across trusts

There was no shared protocol about discharge or transition among the six hospitals. Two hospitals provided a protocol with discharge guidelines and one of them stated that they also followed NICE guidelines for patients in transition to adult services (released Feb 2016). This document included several aspects of young people's care from the point of referral to FCAMHS to discharge. The section referring to discharge included a pre-discharge meeting or CPA review according to the MHA and Section 117 (mandatory after-care) that should be attended by the responding adult service or adult community mental health team. The other hospital followed similar guidelines for discharging young people. They also provided a discharge checklist involving administrative tasks, risk assessments, a discharge pack with the patient's history and medical conditions and care-coordinator to plan discharge according to section 117. The discharge document aimed also for parental involvement in line with CPA plan.

Table 11. Protocol comparison between hospitals

Protocol theme n=2	Hospitals 1 and 2
Agencies involved in the protocol	Local authorities in the person's geographical area, FCAMHS, AMHS or YOT/custody, social services
Specified duration of transition planning	No
Joint working pre-discharge	Yes with MDT and receiving services
Risk assessment	Final outcome measures to be completed
Joint working post-discharge	No follow up was mentioned in the protocols. Hospital 1 mentioned administrative computer-and paperwork
Information to be transferred	Discharge summary sent to all health agencies involved, young person, family.
Therapeutic relationship ending	Hospital 1 referred to ending letters for young person and family
CPA used to discharge	Yes sometimes along with a pre-discharge meeting. Pre-discharge CPA was deemed appropriate for discharging young people.
Procedures when transitions delayed	None of the protocols included such details. All young person under MHA are entitled to aftercare Sec 117

Transition boundary	18 years
Parental involvement	Carer's assessment and CPA attendance/in case the young person is discharged home medication advice

Each local collaborator elaborated on several components of the transition process and they highlighted similar and different aspects. A small transition process questionnaire (Table 14) was included in the mapping exercise and consisted of six questions with three possible answers and there was an additional prompt in case clinicians wanted to elaborate on how they carry out transitions.

Table 12. Transition process: aims for patients making a transition

	Documented handover planning	Joint meeting with adult service	Involvement of parent/carer in care plan	Involvement of the service user in care plan	Preparing for next therapeutic relationship	Accountability for the process
1	always	always	always	always	always	always
2	always	always	always	always	always	sometimes
3	always	always	always	always	always	always
4	always	sometimes	always	always	always	always
5	always	always	sometimes	always	always	sometimes
6	always	always	always	always	always	always

They all answered that they manage transitions always or sometimes with documented handover planning, joint meeting with adult services, family and service users' involvement, preparing for new therapeutic relationships and collaborating with adult clinician. They all referred to the Care Programme Approach (CPA) discharge meeting. When they asked to elaborate on the transition process, they responded:

Hospital 1:
"Within service standards provided. In high risk cases abruptly transfer patients-although rare- to deescalate violence. Patients are not informed deliberately when and what time they are transferring."

Hospital 2:
"We attempt to identify the responsible mental health team in the community early in the admission. The unit social worker and responsible clinician (consultant psychiatrist) take the lead on identifying a suitable discharge plan and making referrals. A section 117 discharge planning meeting is always held. If transferring to custody, we invite the Youth Justice Board (YJB) placement team and the mental health team of the prison. Discharge planning is an agenda item on ward round minutes and CPA minutes for admission. We try and arrange a graduated discharge plan when possible-often using extended section 17 leave."

Hospital 3:
"The referral process starts at least 3 months prior transition. First the case is discussed over the phone with the responsive services and then the required documents are sent over (e.g. risk assessment, offence, last CPA meeting). Next, the adult service is invited to liaise with the FCAMHS-respective disciplines match (e.g. nurses from the unit with nurses from adult services etc.). Last, a discharge meeting is scheduled. The transition process varies depending on the service.

Usually, young people discharged to the community or CMHTS transition faster than those who are moving to adult forensic services, such as low and medium secure units. The cases discussed would make a transition between 6 weeks and 3 months."

Hospital 4:

"We try to discharge young people to outpatient services and community teams through adopting a relational approach model. The young person is starting getting prepared as early as possible to ensure a smooth transition. Families are highly involved in the process. Joint meetings with adult services are attempted and achieved in most cases. When young people are transferred to inpatient services, we even follow-up in three CPA meetings. There is no follow-up in the community, as there is no commission for this."

Hospital 5:

"-all about by book
-formal relapse prevention work
-RC in lead of 117 & CPA process
-sometimes visit
-meet with staff from receiving unit
-make use of technology, e.g. skype
-provision of information."

Hospital 6:

"The transition process is highly dependent on a number of factors, sometimes the preparation is not possible because individual commissioners may insist on a rapid transition to an adult inpatient service even if an individual patient is on track to achieve a move into the community. Sometimes patients are discharged at Tribunal and the usual planning period is not available. Generally, the liaison with locality including adult services that will be taking over their care takes place as part of the CPA/117 process and discussions about what we are aiming

for in terms of discharge are discussed from the initial CPA/117 meeting after 12 weeks.

All patients are referred for a gatekeeping assessment from the identified locality adult services' gatekeeping clinician 6 months before their 18th birthday. Please note this information is about patients from England only."

Table 13. Transition process themes

Themes	Positive	Negative
Transition preparation	CPA meeting graduated discharge plan formal relapse prevention	abrupt transfer for high-risk cases three months prior transition commissioners insist on rapid transitions
Transition destination	community transitions smooth	adult medium and low secure hospitals delayed transitions
Discharge planning	family involvement	family is not part of decision making
Follow-up	follow-up up to three months in inpatient services	no follow-up in the community

6.4 Discussion

6.4.1 Age transition boundaries

The findings suggest that the transition age boundary is an additional barrier within the transition process. For instance, transition delays were integral of the process despite having 19-year-olds waiting for their transition for more than one year. Age boundaries do not facilitate the transition process that is highly determined by bed availability in adult secure services. The legal system overlooks the burden of transitions by adhering to rigid age criteria. Further, young people often move to adult wards once they turn 18 years where they are surrounded by much older patients who have been hospitalised in forensic services for long periods. Adult wards might not be the most appropriate clinical

environments for young adults (Wheatley *et al.,* 2013) and the wide age range could be problematic and unsafe.

6.4.2 Clinical characteristics of young people and available services

Young males admitted to forensic inpatient units tend to be diagnosed with psychosis much more often than females (Hill *et al.,* 2014). Psychosis was quite prevalent in this group and, particularly among males in contrast to the current literature whereas psychosis among detained young offenders is relatively low (Fazel *et al.,* 2008; Grisso, 2008). However, young people detained in forensic mental health hospitals present with serious mental illness and require more acute and specialised treatment. Conduct disorder was common in this sample and in line with previous research (Pilling *et al.,* 2013). Conduct problems might indicate antisocial personality disorder later in life and early intervention with parent-training programmes is highly recommended (Meier *et al.,* 2011).

The results draw the attention to emerging personality disorders and, specifically Borderline Personality Disorder (BPD) across young females, and the risk of self-harming. However, we should take into consideration that emerging BPD might not explain these symptoms that might derive from developmental trauma, as many of these young people have been abused or neglected (Dimond and Chiweda, 2011). Nevertheless, borderline symptoms present as a way of responding to insecure attachment styles and past trauma (NICE, 2009). The diagnosis of personality disorders usually delays until 18 years and even later, as clinicians have been hesitant to diagnose adolescents with personality disorders (Meier *et al.,* 2011). However, many of these patients presented with persistent personality traits indicative of personality disorders. These findings are conjunctive with the existing literature on BPD symptoms presenting during early and late adolescence (NICE, 2009). CAMHS and forensic child services should include in their transition planning agenda appropriate care-pathways

for young people with suspected BPD. The NICE guidelines on BPD emphasise that child health care providers should plan extremely carefully this group's transitions when they are terminating relationships.

Transitions are even more perplexing for young people with BPD, as relationship instability is part of their symptomatology. Therefore, one, of the units, that mostly accommodates young female patients with BPD symptoms has built an attachment and trauma model to address these problems and prepare this group (Hill *et al.,* 2014). There is clearly a link between aggressive behaviour and emerging BPD symptoms.

Neurodevelopmental disorders and learning disabilities were common in two hospitals that specialise in these kinds of difficulties and provide supportive care for this group of young people. Previous research has found that young people with ASD and learning disabilities and comorbid mental disorders belong probably to the most vulnerable group of young offenders in transition of care. The lack of services for specialised treatment (Lamb and Murphy, 2013) and the lack of readiness for moving to adult services could exacerbate their current symptoms. Lamb and Murphy (2013) highlight that readiness in terms of developmental versus chronological age should be looked in more depth and implement policy across services accordingly. The criterion of age boundaries is problematic for young people with learning disabilities whereas chronological age does not match the developmental one. Young people with neurodevelopmental problems could move to adult-appropriate services when their care in child services needs to end (Livanou *et al.,* 2017). One American study measuring readiness for transition among young people with ASD and impaired cognitive functioning found that this group was less developmentally prepared for such a transition (Sawicki *et al.,* 2009). Nevertheless, we need more studies assessing readiness among vulnerable young people to tailor transitions on a person-need basis.

6.4.3 Demographics

Another important finding was that majority of the patients were of white ethnic backgrounds in contrast with overrepresentation of black and ethnic minority groups in detention settings. According to the NHS Confederation (2016) factsheet Blacks and Ethnic Minorities are overrepresented and black people are three times more likely to be detained under the Mental Health Act. Yet, one unit had BME at the time of the mapping exercise. Overall, the clinicians mentioned that the unit mostly accommodates young people from diverse backgrounds. The number of females was not extremely low, which could mean that more attention is given to young female offenders, as previously thought. Bluebird House, that is a mixed gender unit had the highest number of female patients and mostly admits adolescent female offenders (Hill *et al.,* 2014). All females in this study but one, who was admitted in accordance to section 37 (the court orders hospital treatment), were detained under section three of the MHA. This is inline with the literature's findings whereas female inpatients in forensic units were not prison transfers portraying the low number of females in UK prisons (Hill *et al.,* 2014). This study included 10 female patients that is consistent with admissions in forensic adolescent units-30 female patients were admitted within a four-year period in Bluebird house.

6.4.4 Continuity of care

Hospital destinations could be of low priority to clinicians when moving young patients (Hill *et al.,* 2014). However, the complexity of some cases in the current sample including high-risk might have required transition to secure services. More than half of the young people moved to a secure hospital whereas the majority transferred to an adult medium secure ward. These findings need more consideration about continuity of care. Continuity of care is quite established in relevant legislation and all discharged young people are entitled to aftercare. However, a great proportion remained in forensic services and did not step down. As one clinician mentioned, key workers from child services might follow-up with young people up to three months after their move

to inpatient settings. Yet funding is not provided to sustain relationships with young people in the community. Prolonging young people's stay in the system normalises hospitalisation. Long-stay in inpatient settings reduces the quality of life and the chances of having a successful return to the community (Leff and Trieman, 2000).

6.4.5 Transition delays

The Joint Commissioning Panel for Mental Health (2012) pinpoints that administrative delays should be avoided during transition and commissioning parties should manage to collaborate for timely transitions. However, it is evident from the results of this mapping exercise that many patients fall in the gaps of services and wait for a collaborative decision to be transferred to adult services. Transition outcomes clearly depended on waiting time in between services. Therefore, it is imperative that commissioners and clinicians from both child and adult services make joint decisions facilitating the transition process (Lamb and Murphy, 2013). It looks that young people transitioning to adult secure hospitals experienced longer waiting than those moving to community services.

6.4.6 Discharge management and preparation

In line with TRACK'S results, it is evident that rigid age criteria, complexity of cases, transitional delays, long waiting lists and lack of consistent transition protocols lead to poor transition outcomes. While all respondents reported that young people are prepared for their transitions, there was no shared protocol explaining how this goal is achieved apart from CPA meetings. CPA planning was adopted by all hospitals to decide about young people's transition pathways. This is consistent with the TRACK's study findings whereas London trusts' protocols included the use of CPA to determine about eligibility of the young person for adult mental health services (Singh *et al.,* 2010).

All units seemed to share similar goals about education, prosocial/protective factors build up to transition planning and

preparation approach. However, the complexities of this group and each case separately turn discharge into a complicated process where responsible clinicians have to adapt to the special circumstances of the young person. Considering that forensic child cases involve multiple services collaboration including social care, local authorities and commissioners, mental health services and the justice system, MDT try to achieve as an optimal transition as possible. However, in cases with safeguarding issues involving high-risk patients, this is not feasible and clinicians have to consider public and ward safety. Young people returning to custody are often a high-risk group that need additional precautions for transition preparation and management. Accordingly, transition preparation and management should be handled differently as the young people may not be informed about their transition destination ahead of time. On the other hand, this might bring more distress and -cause aggressive behaviour.

One ward specifically was more explicit in terms of the model of care approach they implement on transitions. The Wells unit has also published relevant information concerning the relational model approach they integrate in their clinical practice and how they promote protective factors to move young people's continuity of care to the community instead of inpatient services (Dimond and Chiweda, 2011). This child forensic unit relies on *relational security* to build trusting therapeutic relationships between staff and patients. Similar reports from other units might be helpful in comparing processes and treatment models across hospitals and to aim for joint -collaboration.

The two discharge protocols highlighted that FACMHS organise pre-discharge meetings with all involved teams, as is mandatory by the relevant legislation (MHA-Section117). It was mentioned that members of staff from child and adult services should coordinate transitions and should share their views on risk assessments. Nonetheless, these protocols did not specify what their clinical approach is about transition preparation.

The clinicians reported that they aim for handover planning to adult services, parental involvement and preparing the young person for the next therapeutic relationship. Yet, these goals might not be successfully achieved. Findings from previous studies have shown that handover planning is not well managed (Wheatley *et al.,* 2013). Staff from AMHS does not have sufficient training and knowledge on how to respond to newly transferred young people. Child services rely heavily their care model on attachment theory whilst adult services do not integrate the theory in their care approach (Swift *et al.,* 2013).

6.5 Future pathways for young people

It has been discussed multiple times in the literature the establishment of 12 to 25-year-old services to serve adolescents and young adults (Birchwood & Singh, 2013). The aim of these age-appropriate services is to reduce the number of transitions young people are experiencing at the moment. However, the model of a ‘‘youth mental health service’’ is not widely accepted whilst it is argued that the existing model of child and adult services should be improved instead of replaced (Brodie *et al.,* 2011). Considering the findings of this mapping exercise, and the difficulties embedded in transferring young people from forensic child and adolescent national mental health services, the option of a distinct care pathway for this group should be considered.

6.6 Strengths and Limitations

This study comprised a national sample and it was the first study to map young people in transition of care from inpatient FCAMHS using a prospective design.

Including all national child and adolescent forensic mental health services allowed for comparisons across hospitals and paved the pathway for areas of future research. The aims of this study fit the strategy of the Department of Health for good mental health among children and young people and governmental priorities on mental health

and policy. The patients were identified in a consecutive manner; however, during follow-up with the hospitals there were no additional eligible people for transfer to adult services.

This study entailed some limitations given the short time frame of six months. The results cannot be generalised to the broader forensic mental health population but still are indicative of certain difficulties and infrastructural weaknesses of current forensic mental health services in England, as they represent a national sample. Young people in forensic inpatient hospitals belong to a very particular group within mental health care services with ongoing complex needs. The number of young people transitioning from FACMHS is much lower compared to those moving from general CAMHS and would explain the low number of individuals moving to adult services. It should be noted that FCAMHS admit a low number of young people on an annual basis based on the results of this study. One report released by a London based inpatient FCAMH (Wells Unit) points out that they only accepted 55 young people between 2006 and 2011 (Dimond and Chiweda, 2011). For the purpose of this study, I included a specific cohort those close to 18 years and eligible to be discharged to adult services based on age criteria and I did not include younger people transitioning to other child services to meet the aims of my area of study.

Many delays occurred throughout the study, as it involved six different hospitals across widespread geographical locations. After approval from the South Birmingham Committee in January 2016, the study did not commence until late June 2016. This occurred because R&D Approval processes changed in late March 2016 and I had to abide by the new HRA process. I had to reach the sites in advance and I had not received responses from three sites until March 2016 in order to identify a potential Local Collaborator/Principal Investigator. I had to visit the sites multiple sites and the mapping exercise was returned incomplete most of the times due to clarification issues. There were problems with retrieving and accessing the relevant data asked in the mapping

exercise; certain questions took up to six months to be answered fully. Transition delays with many young people being stuck in FCAMHS postponed data collection too. Transition destination was not known to the clinicians- for some patients- as long as discharge date for most patients.

6.7 Conclusions

This mapping exercise has elicited important information regarding national transition processes and outcomes followed by forensic child and adolescent mental health services. This study included all six nationally commissioned medium secure services for adolescents and looked at their policy and practice pre-peri- and post-transition. This mapping tool extended knowledge in the existing literature by looking at the national caseload across FCAMHS. This study identified the demographic and clinical characteristics of young people accommodated in forensic settings alongside index offence and Mental Health Act status. Hitherto there was no information on the profiles of young people at a national level.

Transitions from FCAMHS to adult services was an under-researched area within the existing literature. Transition processes and outcomes from these services were not known and, therefore, we could not address the barriers and facilitators to improve policy and practice. More importantly, this study added findings regarding young people's discharge placements and transition timelines at a national level. The results revealed that majority is transferred to forensic adult hospitals and waiting time from referral to discharge varies significantly and can result in severe transition delays. This data is necessary to build a national database and also to develop an understanding of young people’s care-trajectories to address and reflect on young people’s needs in periods of transitions. This study also addressed the current gaps in forensic adolescent inpatient services regarding policy and practice. The findings from this study showed that services lack of uniform transition guidelines

in the form of a forensic transition document was one of the problematic areas that can lead to inconsistent practice across services.

A majority of these young people had specialised needs and comorbid mental health problems corroborating the prevalent notion that this group presents with complex needs. This study though looked at what particular needs this group presents with. Additionally, most young people were detained under Section 3 of the Mental health Act and had committed an assault showing that they also present risk to the public.

There is a limited number of current reports from forensic child and adolescent inpatient services. Therefore, a national standardised database for FCAMHS would facilitate coordination between services (Signorini *et al.,* 2017). This mapping exercise showed that there are no national databases on young people's transitions. More research is necessary to understand where services stand transition-wise and what processes they follow to protect young people from poor transition outcomes. The next chapter is an analysis phase three of the research study, which is the case note review, and examines the transition care-pathways of young people discharged from forensic inpatient units including annual transition rates, demographics and characteristics of this group.

7 Transitional pathways among young people discharged from forensic child and adolescent mental health services: A retrospective national case note audit

"They explained that were getting 'detained.' I didn't know what 'detained' meant. They didn't really explain where we were going or what we were going to do."

(Children's Commissioner, 2017)

7.1 Chapter overview

This chapter is an analysis of Phase 3 and comprises a case note review that used a retrospective design to look at the medical and personal records (e.g. forensic history, mental health, family background, education background (based on Care Programme Approach (CPA) and discharge summary reviews from each hospital) of those young people discharged from inpatient FCAMHS between May 2015 and June 2016.

7.2 Research question

What are the annual transition rates and pathways from FCAMHS?

7.2.1 Aims

This study examined the complexities and transitions of discharged cases to adult mental health services during the preceding year. This stage included participants detained in all national medium secure adolescent mental health services under the Mental Health Act between May 2015 and June 2016 and aimed:

- to identify the numbers of transitions from adolescent forensic secure mental health units to adult forensic secure units, community, adult psychiatric hospitals and custody;
- to describe the sample regarding transition including referral

pathway, length of stay, time from referral until discharge, continuity of care (adult placement), transition destination, process of transition (barriers or factors that fostered transition), and transitional pathway;

- to examine describe the sample regarding demographics (gender, ethnicity), age at the time of discharge, education status, family involvement and relationship;
- to examine the sample regarding clinical characteristics including risk factors and offences;
- to describe the sample regarding legal status (MHA section) and index offence;
- to examine the sample regarding past trauma (e.g. sexual abuse, domestic violence), parental mental health status, transition destination, length of stay, index offence, MHA section and clinical characteristics of the patients, such as diagnosis;
- to examine similarities and differences across case note reviews that signify typical and atypical cases.

7.3 Results

Thirty-two retrospective cases were examined and explored at the same time to elicit an in-depth understanding on transitions and the characteristics of young people admitted to FCAMHS and transitioning to adult mental health services (Crowe *et al.,* 2011). The results about clinical characteristics, demographics, index offence, parental mental health status, educational status, responsible carer, past abuse, and transitional pathways are displayed in tables and figures.

7.3.1 Number of transitions

Thirty-two patients were discharged to custody, community, adult mental health (inpatient services) and community services between May 31st 2015 and June 1st 2016. These patients had reached 18 years or were between 17.5 and 18 years. One young person moved to an adult inpatient hospital before their 18th birthday due to high-risk

presentation. The average number of transitions for that year was 5.3 (*SD*=1.4, *Mdn*=5) for all hospitals and did not differ greatly among hospitals. The number of transitions to adult services per hospital ranged between 4 and 7.

Table 14. Number of transitions between May 2015 and June 2016

Medium Secure Unit	Number of discharged patients between May 31st 2015 and June 1st 2016
Hospital 1	4
Hospital 2	7
Hospital 3	7
Hospital 4	5
Hospital 5	4
Hospital 6	5

7.3.2 Demographics

This cohort included 75% males and 25% females. The sample consisted of 62.5% White British, 6.3% White Scottish, and 3% of other white ethnic groups whereas only 16% were Black British and 3% Black African and the remaining 9% from mixed and South Asian and Arab backgrounds.

7.3.3 Education

All young people who are accommodated in FCAMHS have to attend educational courses. Yet, the educational level of each young person varied significantly depending on each individual's needs and developmental age. Many of these young people would not engage in education due to the severity of their mental illness or engagement might had been inconsistent. The results are displayed on Table 14. It has been reported that many of these young people would automatically disengage from education once they turned 18 years and were still in FCAMHS, as it was stated in their records when young people were described as disengaged.

Table 15. Education level and needs among young people in FCAMHS

Education	N=32	n (%)
12th grade courses	13	40.6
GCSE in Math & English	3	9.4
college courses	4	12.5
disengaged	3	9.4
only music classes	1	3.1
part-time due to ADHD and Tourette's	1	3.1
remedial education	1	3.1
Unclear/not recorded	5	18.8

7.3.4 Diagnosis and mental health problems

Psychosis (44%) was the most prevalent mental disorder followed by learning disabilities (41%), self-harming incidents (41%), PTSD (28%). Schizoaffective disorder was common in 25% young people and ASD in 22%. Emerging BPD was evident in 19% young females and depression disorders in 9% of them. Nine per cent presented with Asperger's syndrome. Eating disorders were reported for 2% and the same rate applied for OCD, ADHD, and ASPD. Thirty patients had at least two mental health problems and/or learning difficulties and/or self-harming symptoms. Only three young people had one mental disorder, which was psychosis. Four young people had two mental disorders and mental health symptoms and the remaining had at least three. Three young people had also attachment problems. Two people had borderline LD, three people had mild to moderate LD, two young persons had mild LD and one person had severe LD. For the rest of the young people LD severity was not specified.

Table 16. Mental health problems, symptoms and learning disabilities among young people in FCAMHS

Mental health problem	(N=32)	n (%)
Depressive and bipolar disorder	3	9.38
Psychosis	14	43.75
Schizoaffective disorder	8	25
PTSD	9	28.13
Eating disorders	2	6.25
Obsessive Compulsive Disorder	2	6.25
Learning disability	13	40.63
Autistic Spectrum Disorder	7	21.88
Asperger's syndrome	3	9.28
Attention Deficit Hyperactivity Disorder	2	6.25
Antisocial Personality Disorder	2	6.25
Borderline Personality Disorder	6	18.75
Self-harming	13	40.63

7.3.5 Length of stay

For five patients no data could be obtained. Length of stay in FCAMHS was provided for 27 patients. The relevant information could not be found through their records and the responsible clinicians could not retrieve discharge dates for these five missing patients. The average length of stay was 19 months (*SD*=16 *Mdn*=14) and ranged between 1 and 72 months.

7.3.6 Transition delays

Waiting time from referral to discharge was calculated for 26 patients. Five patients were discharged to adult services a few weeks before their 18th birthday and waiting time was unclear for one young person. The average waiting time was 6 months (*SD*=4, *Mdn*=5) and ranged between 1 and 16 months.

7.3.7 Mental Health Act

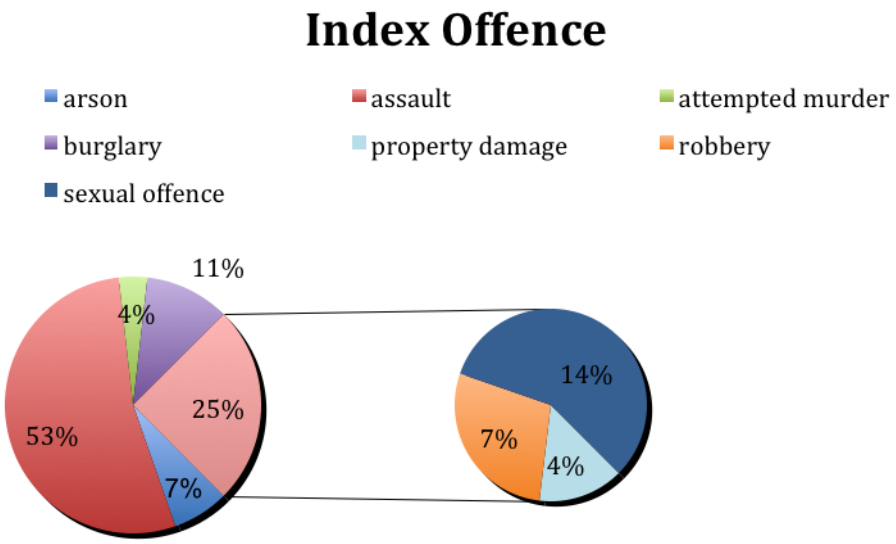
Majority of young people were detained under section three of the MHA. A few people were detained under notion 37 (court order) and

some others had been transferred from prison on a restriction order 47/49 (sentenced) or 48/49 (on remand). One patient was on section 48 transferred to hospital but not sentenced. One other patient was under part 2 of the MHA that is the civil section (have to receive care within medicolegal framework).

7.3.8 Index offence

About 54% of the young people had assaulted either a family member or a staff member from previous placements in psychiatric hospitals. The second most common offence was sexual assault (14%). About 11% of young people had committed a burglary, 7% a robbery, 7% arson, 4% property damage and 4% attempted murder. It should be noted that almost all this cohort had offended previously and these were not the only offences in their forensic records (Figure 11).

Figure 13. Index offence among 32 young people discharged from FCAMHS during 2015/16



7.3.9 Parental mental health & abuse

Fifty-three per cent of the sample had at least one parent with a mental health problem and about 38% had experienced sexual abuse from a parent, sibling, another family member or peer.

7.3.10 Primary carers

Majority (41%) had been raised by their parents whilst 22% were looked after children (LAC) and 19% had been living within single-parent families (mother). Their grandparents had raised two young people, one person with mother under child protection plan and one other with parents and social services involved. For two young people, no relevant information was provided in their records.

7.3.11 Age at time of discharge

About 66% of the sample was above 18 when they transferred to adult services whilst 31% were between 17.5 and 18 years when they moved to adult services. One person was 20 years when she left FCAMHS.

Table 17. Patient demographics and clinical characteristics

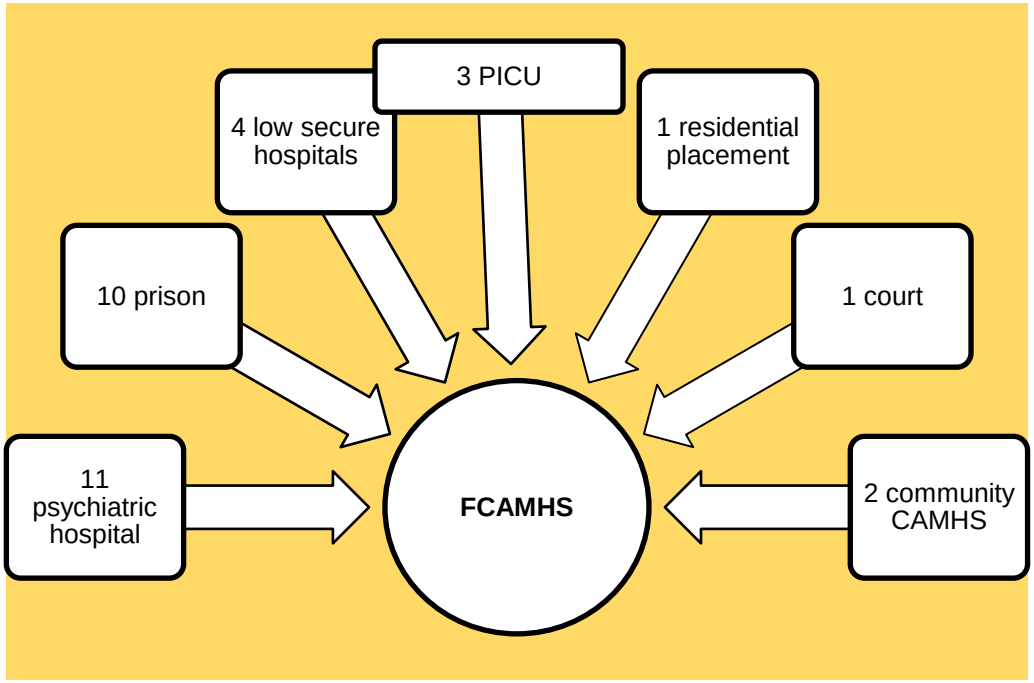
Characteristics	(N=32)	n (%)
Gender		
Females	8	25
Males	24	75
Ethnicity		
White British	20	62.5
White Scottish	2	6.3
White other	1	3.1
Black British	5	15.6
Black African	1	3.1
South Asian	1	3.1
Mixed	1	3.1
Arab	1	3.1
Age at time of discharge		

17.5-18 years	9	31
18.1-19.5 years	19	65.5
19.5-20 years	1	3.4
Carer		
Parents	13	40.6
Mother	6	18.8
Grandparents	2	6.3
LAC	7	21.9
Mother-child protection plan	1	3.1
Parents-social services involved	1	3.1
Unclear	2	6.3
Sexually abused or Domestic violence		
Sexual abuse	12	37.5
Domestic violence	4	12.5
Not abused	16	50
Parental mental health problem		
Yes	17	53.1
No	15	46.9
Mental Health Act		
Section 2	1	3.1
Section 3	21	65.6
Section 37	3	9.4
Section 37/41	1	3.1
Section 47/49	3	9.4
Section 48	1	3.1
Section 48/49	2	6.3

7.3.12 Pathways from previous placement to FCAMHS

Eleven people were referred from a psychiatric hospital to FCAMHS, followed by ten young people referred from a YOI, SCH or STC. Four people were transferred from low secure hospitals and three from psychiatric ICU including one adult PICU. One person was referred from court to FCAMHS and another one from a residential placement. One person was previously in residential services and then moved to FCAMHS. Two young persons were referred from outpatient CAMHS as they were living in the community.

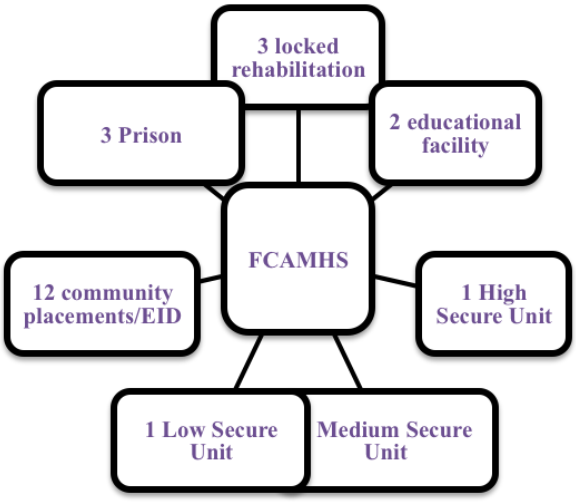
Figure 14. Discharge destinations to FCAMHS



7.3.13 Pathways from FCAMHS to adult placement and community settings

Twelve young people were moved to community placements including Early Intervention Services. Eight young people were moved to adult medium secure hospitals, one went to a low secure unit and another young person to high security. Three young people went back to prison and three were discharged to locked rehabilitation services. Two young persons were transferred to an educational facility. Two young people were sent to psychiatric hospitals.

Figure 15. Discharge destinations from FCAMHS



7.3.14 Transitional patterns in care-pathways

Four main patterns were identified regarding the transitional care-pathways of these 32 young people including previous placement, FCAMHS-that was common in all patients- and discharge placement. Twelve young people shared four distinct care pathways. Timelines could not be estimated, as this information was not provided in their records for each placement they were accommodated. Three young people were referred from a YOI to FCAMHS and then to an adult medium secure hospital. Three young persons were referred from a psychiatric hospital to FCAMHS and to an adult medium secure hospital. Four young people were referred from a psychiatric hospital to FCAMHS and then to community services. Two young people were referred from a YOI to FCAMHS and then went back to adult prison.

Figure 16. Transitional pathways for young people

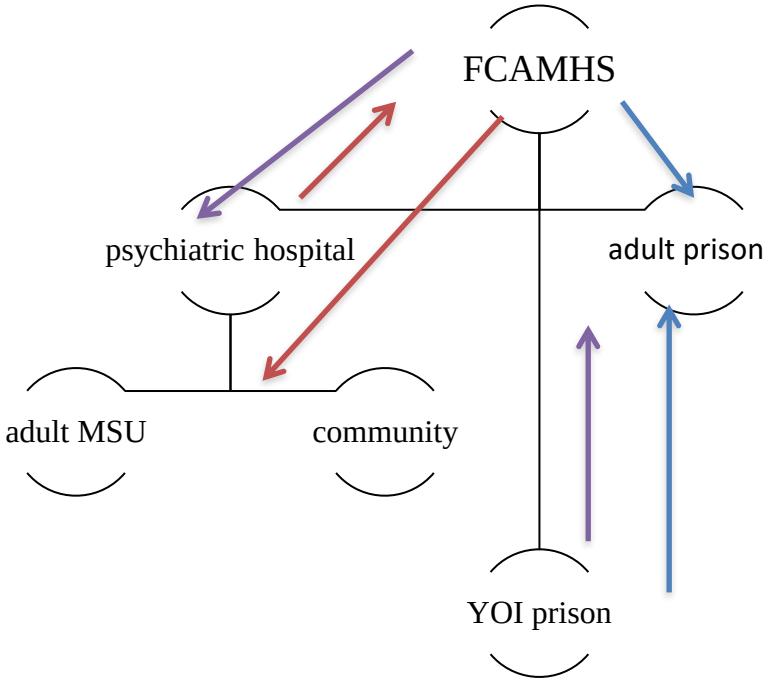


Table 18. Summary of 32 cases of discharged young people from FCAMHS between 2015 and 2016

Young Person	Gender	Ethnicity	Parents MH	Sexual abuse	MH problem	Care/ Pathway	Offence	Discharge Age	Final setting
1	Female	WB	OK	Yes	BPD, PTSD, self-harming, paranoid schizophrenia, attachment DO	mother	attempted arson, assaulted staff and absconded from FCAMHS	17.11	community setting
2	Female	WB	Yes	Yes	BPD, PTSD, self-harming, eating disorder, attachment DO	grandparents	risk	18.2	MSU
3	Female	SA	M-Yes	No	BDD, OCD, PTSD,CD, autistic traits, self-harming	mother	sexualised behaviour, violent towards staff	18.6	Community supported accommodation
4	Female	WB	YES Both	Yes	BPD,CD, depression, PTSD,	Foster	assaulted member of staff	18.5	residential rehabilitation services
5	Male	WB	Yes Both	No	psychotic depression, self-harming,	UNKNOWN	burglary	before 18	prison

					substance abuse				
6	Male	Mixed	M-yes	Yes	schizoaffective DO, atypical autism, CD, substance abuse	grandmother	property damage, staff assaults, illicit drugs, sexualised behaviour	17.11	Community supported accommodation
7	Female	WB	OK	No	BPD, ASPD traits, eating disorder, self-harming, OCD	parents	assaulted staff member	18.7	MSU
8	Male	WOTHER	Yes-Both	No	ASD, dyslexia, enuresis	mother	7 sexual offences of minors/had attempted to kill his mother	19.4	locked rehabilitation
9	Male	BB	No	No witnessed violence	psychosis, self-harming	mother	assaulted staff members, attacked to peers	17.9	educational facility
10	Female	WS	No	Yes	Asperger's, attachment DO,PTSD,CD,BPD, borderline LD, self-harming, past concerns for psychotic illness	LAC (mother in prison)	assaulted members of staff	18.8	MSU

11	Male	WS	M-Yes (father in prison)	Yes	psychosis/paranoid schizophrenia, ASD traits, self-harming, PTSD	parent/mother	assaulted member of staff, attempted to kill his mother	UNCLEAR	EIS/CMHT
12	Male	WB	No	No	CD,ASPD traits, ASD, self-harming	parents	attempted murder	18.11	prison
13	Female	WB	No	Yes-brothers	bipolar disorder, CD, antisocial traits, borderline LD	parents	weapon assaults, property damage	18.4	PICU
14	Male	WB	Yes	Yes	PTSD, paranoid schizophrenia, OCD	LAC	violent behaviour in previous placement	18.2	LSU
15	Male	WB	No suicide history in family	No	schizoaffective disorder, PTSD, ADHD, ODD,CD, self-harming	LAC	burglaries, robberies, assaults, arson and sexual offences	18	MSU
16	Male	WB	Yes	No	schizoaffective disorder, mild LD, attempted suicide	LAC	assaulted members of staff	18.3	MSU

17	Male	WB	No	No	mild LD, Asperger's syndrome, CD ,hyperkinetic disorder, self-harming	parents	high-risk sexualised behaviour-public masturbation, sexual preference in children and animals, child pornography	18.6	MSU
18	Male	WB	Yes	Yes	ASD, mild LD, schizoaffective disorder, paranoid schizophrenia, OCD, and attempted suicide	parents	violent towards mother	18.1	psychiatric hospital
19	Male	WB	Yes	No	social & specific phobias, mild LD, ASD, depression and suicidal ideation	mother & child protection plan	property damage	UNCLEAR	locked rehabilitation
20	Male	WB	No	No	severe LD, ASD, bipolar disorder	parents	violent towards parents and staff assaults in previous schools	18.1	educational facility
21	Female	Arab	No	No	schizoaffective disorder, mild to moderate LD	parents	aggressive incidents in LSU	20	EIS

22	Male	BB	No-but other family had MDs	No-witnessed domestic violence	schizoaffective disorder, mild to moderate LD,CD	parents	assaulted members of staff	17.11	community setting
23	Male	WB	Yes-	Yes	schizoaffective disorder, mild LD, CD	mother	property damage, arson,theft	17.11	community setting
24	Male	BB	Yes	No-witnessed domestic violence	schizoaffective disorder, speech and language difficulties	parents	aggression to mother	UNCLEAR	EIS
25	Male	BB	No	No	psychosis	parents	assaulted staff members	18.2	home/EIS
26	Male	WB	No	No	psychosis, expressive language difficulties	parents	assaulted members of staff	18.1	home/EIS
27	Male	BA	No	No	psychosis	mother/foster care	robbery	18?	prison?

28	Male	BB	Yes	Yes	paranoid schizophrenia, self-harming	parents-social services involved	assaults, theft, burglary, property damage	18.1	MSU
29	Male	WB	No	No	psychosis, Asperger's syndrome, depressive and anxiety disorder	father/foster care	assaulted staff members	18.1	community setting
30	Male	WB	Yes	No-witnessed domestic violence	psychosis, ADHD,LD	parents	assaulted staff members	18.7	community setting
31	Male	WB	Yes	Yes	psychosis, PTSD, emerging BPD, self-harming	parents	sexual assault against a young girl	18.4	MSU
32	Male	WB	No	No	paranoid schizophrenia	UNKNOWN	robberies	17.12	HSU

7.3.15 Case Note Reviews

The following vignettes present typical and atypical cases

Patient 1

This White British female had a long history of self-harm and suicide attempts along PTSD potentially from past sexual abuse. At the time of transfer she was diagnosed with paranoid schizophrenia, emerging BPD, PTSD and presented signs of attachment disorder. She had a long history of self-harming behaviours including overdose and tying ligatures. She had been in part-time education due to ADHD difficulties and Tourette's syndrome. Her mother was quite involved and the patient had weekly phone calls with her. The patient had assaulted members of staff before transferred to the unit and had attempted arson. The patient had absconded from FCAMHS. She was referred from SCH to FCAMHS and was detained under section three of the MHA. She had communicated to her peers that she would like to kill certain staff. However, at the time of discharge she presented moderate risk and her clinicians reported on her progress. They believed she was ready to move to a community placement but would need support given her vulnerability. She was discharged one month before turning 18 years.

Patient 2

This White British female presented with emerging BPD, attachment disorder traits and PTSD due to past sexual and physical abuse. She was transferred to FCAMHS from another secure hospital, as they were unable to manage her risk. The patient was detained under section three of the MHA. She had been engaging in self-harming and had attempted suicide multiple times, resulting in hospitalisation and treatment. The patient had a restricting diet and refused food and liquid intake at times. This female has been in contact with CAMHS from 11 years. Her mother had a mental disorder and, therefore she was raised by her grandparents. She has been bullied at school and had inconsistent education at the moment.

After two months of turning 18 years, she transitioned to an adult medium secure hospital.

Patient 3

This British born South Asian female patient presented with predominantly Body Dysmorphic Disorder (BDD) and OCD along with PTSD, conduct disorder, and autistic traits. She was referred to FCAMHS by another hospital due to her aggressive and violent behaviour towards members of staff. She was detained under section three of the MHA. The patient had expressed violent behaviour to her family and had been bullied since in primary school. Her mother had a history of past mental disorder-postnatal depression- and did not establish a bonding relationship with her. The patient had a few incidents of self-harming and exhibited sexualised behaviour to staff. However, her risk was considered moderate and had progressed since admission. The patient was often disengaged from her education. She was discharged to supported accommodation in the community after six months of turning 18 years.

Patient 4

This White British female patient presented with hyperkinetic disorder, Foetal Alcohol Syndrome, emerging BPD, moderate depression, conduct disorder, past suicidal attempts and PTSD due to being sexually assaulted. The patient was transferred to FCAMHS from low secure services and had been in social care since the age of 11 years. However, her aggressive and violent behaviour could not be managed in those services, as she demonstrated significant risk to self and others. She often displayed antisocial behaviour and lacked affect. The patient was detained under section 37 because she had assaulted severely a member of staff in the previous hospital. She has been in foster family since a very early age, as her parents were using substances and were involved in prostitution. The patient was referred to residential rehabilitation services where she had to move before her 19th birthday.

Patient 5

This White British male patient was transferred to FCAMHS from a YOI under section 47/49 of the Mental Health Act, as his mental health symptoms were worsening during his stay there. The patient was serving a 2-year sentence for burglary. However, he had an extensive offending background with assaults on strangers, staff, robberies, and arson. This young male struggled with anger management. He presented with psychotic depression including auditory hallucinations commanding him to hurt other people. The patient had a history of self-harming, suicidal attempts, and substance use. Whilst in a staffed accommodation on extended Section 17 leave, he was in contact with a YOT worker. His mother indicated that she had post-natal depression and her father had schizophrenia. The patient moved back to YOI right before his 18th birthday due to a violent incident and his following mental health pathway was unclear.

Patient 6

This male patient was from a mixed ethnic background and was referred to FCAMHS from a psychiatric hospital due to increased incidents of violence and aggression. He was detained under section three of the MHA. His history of offences included damage to property, assaults on staff, sexualised behaviour, and possession of illicit drugs. The patient was diagnosed with schizoaffective disorder mainly with manic symptoms, atypical autism, conduct disorder, and substance abuse. He also had ASD traits evident in his inability to reflect on his emotions. His mother had also schizoaffective disorder and substance and alcohol abuse problems. Therefore, the grandmother raised this patient. It had also been reported that the young male had experienced home violence at a very early age between his parents. Probably the patient was sexually assaulted multiple times in the past. He had also been accused of attempting to rape a girl with his peers in the community. Whilst in FCAMHS. The patient had exhibited inappropriate sexualised behaviour towards nursing staff

multiple times and had been in seclusion a few times. The patient transitioned to the community in supported accommodation a few weeks before his 18th birthday on CTO and attempts were made to keep his accommodation after he turned 18 years. His family was concerned about his care and accommodation after entering adulthood, as no clear arrangements were made. The patient would attend college coursed shortly.

Patient 7

This White British female patient was admitted to FCAMHS from a psychiatric hospital after she assaulted on a member of staff and her risk level was more appropriate for hospitalisation in medium secure services. The patient was detained under section three of the MHA. This patient was diagnosed with emerging BPD and also presented ASD traits. She had strong suicidal ideation. During times she refused to intake food in order to control and discipline herself. Whilst in FCAMHS she had to stay for very long periods in seclusion due to her consistent urge of harming herself, and staff preventing her from acting upon her urges. This young female had also obsessive-compulsive thoughts and a *perfectionist ideology* resulting in a rigid self-view as being constantly a failure. It was mentioned that her other siblings had psychotic symptoms and low mood at times. This patient was taking A Level Math and Science and performing really well. The patient had experienced the loss of her half-brother a few years ago along with the eating disorder and self-harming issues of her closest friend. Her symptoms appeared during that period with extremely low mood. Due to the patient's long stay in seclusion, it had been quite difficult to identify an adult service that would take her over. A few months before her 19th birthday, she moved to a Women's Enhanced Medium Secure Services (WEMS).

Patient 8

This White other ethnic background male patient was transferred from a psychiatric hospital to FCAMHS due to risk management. He had been convicted of seven sexual offences on minors and was detained under

Section 37/41 of the Mental Health Act; he was on the sex offenders register. This patient presented with ASD and dyslexia and also had enuresis problems before his admission in FCAMHS. At periods of stress he would express thoughts of wishing to die or hurt his self. His father died when he was four at a traffic accident; however, his father was using illicit drugs and was engaged in criminal behaviour and also imprisoned. His mother had mild depression and anxiety and had also attempted suicide with medication overdose in the past. The mother was quite involved in the patient's care. However, due to being assaulted by her son in the past- he also had attempted to kill her, their relationship had been challenging. His grandfather had a psychiatric illness and had been hospitalised. The patient moved to a locked rehabilitation facility four months after his 19th birthday. He had visited the facility a few times before moving and he was anxious in regards to future employment, as he remained on the offenders register. The patient stayed in FCAMHS for almost five years.

Patient 9

This Black British male patient was transferred to FCAMHS from a psychiatric hospital due to his acute symptoms of psychosis. He was diagnosed with treatment resistant psychosis and also presented with sexually inappropriate behaviour and had a history of self-harm. The patient still heard second-person voices. He was detained under section three of the MHA. When his symptoms worsened, the patient would exhibit self-neglect. The patient had been in contact with CAMHS from a very early age when he was about seven years old. He was experiencing high levels of stress at home due to his dad physically and sexually assaulting his mother. They had to move homes due to gang threats. The mother was highly involved in her son's care and was visiting him often. Whilst in FCAMHS he had assaulted three members of staff, attacked physically to peers and had not been engaging in psychological treatment. In regard to education, the patient was working on GCSE in science. He moved to an educational facility that provided team houses three months before his 18th birthday and he would remain there after entering

adulthood. This new placement was closer home and allowed his mother to have more frequent visits.

Patient 10

This female patient of White Scottish background was admitted to FCAMHS from a psychiatric unit due to her violent and aggressive behaviour. She had attacked members of staff several times and could not be managed at the unit. The patient was a looked after child (LAC) and had been in secure children's care for years, as the mother was in prison. Her biological mother and stepfather had abused her physically and emotionally. The mother had been an inconsistent figure in the patient's life that might had led to the patient's attachment disorder. Her diagnoses included Asperger's syndrome, PTSD, conduct disorder, emerging BPD and borderline LD. The patient had been engaging in repetitive self-harming and had thoughts of killing herself. There were also previous concerns she had psychotic illness and, therefore was on psychotropic medication for a long period. Whilst in FACMHS she was attending educational courses and was performing well. She was on a Compulsory Treatment Order (CTO) that was turned into section 3 of the MHA. The patient was discharged after eight months of turning 18 years to an adult medium secure unit specialising in LDs close to her home of origin. However, the patient's transition planning had started before her 18th birthday, as she would need additional time to cope with the prospect transition.

Patient 11

This White Scottish male patient was admitted to FCAMHS due to assaulting severely a social worker whilst in a Children's Secure Home previously accommodated. No charges were pressed against him. He had been in Forensic Community CAMHS in the past due to a serious assault. The patient had a psychotic disorder with hypochondriacal delusions and speciafically was diagnosed with paranoid schizophrenia and was significantly unwell during admission in FCAMHS. He also presented self-neglect and poor hygiene. The patient had ASD traits. The patient had a

history of self-harm and suicidal ideation. He was also diagnosed with PTSD and suffered from intense flashbacks because he had been sexually assaulted at the age of eight years. He had witnessed domestic violence too. His peers at school had seriously bullied the patient. His mother had mental health problems (panic attacks and depression) and had been hospitalized in the past and was on benzodiazepines and antidepressants. The patients had assaulted his mother and tried to kill her in the past. His father was serving time in prison. The patient was detained under section 2 of the MHA. Whilst in FCAMHS, he attended educational courses but lacked motivation and concentration. The patient moved to a Community Mental Health Team, as his risks were reduced, and also received Early Intervention Services for young people with psychosis.

Patient 12

This White British male was referred to FCAMHS from YOI. He was on a discretionary life sentence for a minimum of 7 years, as he had attempted to murder his much younger female neighbour. It seems the patient was obsessed with his victim and had fantasies about them being in a long-term relationship. This was a premeditated action and was carefully planned. Initially he had planned to rape her because she rejected him and was in a relationship with another boy. He was detained under section 48 of the MHA. The patient was diagnosed with ASD upon discharge from FCAMHS. However, for long times his diagnosis of a pervasive developmental disorder had been debatable. He also presented Conduct Disorder with psychopathy traits, as he had no remorse of his action. Yet, he understood what he did was wrong, and he would go prison. At school he was performing excellent and had been a highly intelligent young man. He had only a few communication and social barriers. He was undertaking A Level Maths. The patient presented with low mood and anxiety symptoms at times. The patient grew up in a stable and caring family environment. He did not wish to return to prison once turning 18 years and would prefer to transfer to another medium secure hospital. The patient had engaged in self-harm and had attempted suicide whilst in prison. He

had been bullied at school and in prison before transferring to FCAMHS. His family did not have any mental health history and did not present any past risk factors. He was discharged to prison one month before turning 19 years. However, several attempts were made to transfer him to a medium secure unit specialising in ASD.

Patient 13

This female White British patient was referred to FCAMHS from a psychiatric unit due to her aggressive and violent behaviour towards staff. She had been in her previous placement under Secure Accommodation Order. The patient had a very long history of assaults with weapons alongside property damage. She also assaulted members of staff several times whilst in FCAMHS. She was sectioned under section three of the MHA. She was abusing alcohol and substances since she was 13 years. The patient was diagnosed with rapid cycling bipolar disorder and conduct disorder and presented with antisocial traits. She had a borderline learning disability but not officially diagnosed. She had experienced domestic violence between her parents and her father and brothers had physically abused her. She had nine more siblings who were in Children's Services too, as their mother could not take care of them due to her own mental health issues. The mother had anxiety and depression and the father was an alcohol abuser and very aggressive. The patient was taking educational courses and was performing quite well but her performance could be improved, and she could pursue accreditation. The patient was discharged to psychiatric ICU four months after she turned 18 years.

Patient 14

This White British male patient was referred from psychiatric hospital to FCAMHS due to his deteriorating mental health and, subsequent violent behaviour. He was diagnosed with PTSD, paranoid schizophrenia, and OCD. Whilst in FCAMHS he had sleep difficulties due to his PTSD flashbacks from being abused. His parents abused him physically when

he was a child; his mother probably had schizophrenia and his father had alcohol problems. It was reported that his father had tried to drown him and his brother. He had witnessed domestic violence and after had been in foster care and residential placements. He was a Looked After Care and on Full Care Order. The patient did not have any contact with his family for the past five years and he was afraid of them. The only person from his family he wanted to contact was his brother. He wanted to step down and return to the community but due to his high risk he would need to stay longer in secure services. The patient was detained under section three of the MHA and had assaulted members of staff several times along with his peers and, mostly females. The patient had completed his GCSE in Math and English. The patient transitioned to a low secure unit two months after his 18th birthday.

Patient 15

This White British male patient was transferred to FCAMHS from a YOI under Section 48/49 of the MHA, as he was severely unwell. He had a history of burglaries, robberies, assaults, arson, and sexual offences. The patient was diagnosed with schizoaffective disorder and PTSD. He had also psychopathic and narcissistic traits and was engaging in severe self-harming behaviour. Therefore, his risk for self-harm and suicide was deemed significantly high. The patient also has past diagnoses of ADHD, ODD and conduct disorder. His risk towards others was high too and had assaulted members of staff several times. The patient had been in non-secure care and residential schools when he was a child. His uncle had schizophrenia and his grandmother had committed suicide. He presented with sexualised behaviours from a very early age and committed a sexual offence later on. The patient had been excluded from schools multiple times in the past and had a poor education history and stated he had not attended school from year two. He received his education in SCHs and STCs. Whilst in FCAMHS he demonstrated no interest in education but was attending educational core courses. The patient was transferred to an adult medium secure unit three weeks after his 18th birthday.

Patient 16

This White British male patient was transferred to FCAMHS from SCH. This was the second medium adolescent secure unit he was transferred to due to his learning disability. The patient was diagnosed with schizoaffective disorder and mild LD. The patient presented with auditory hallucinations telling him to hurt other people. He has a history of alcohol and drug abuse and has attempted suicide in the past. His mother was unable to take care of him and his brother who had ADHD and behavioural problems and they were under foster care. The patient had been in care since the age of 6 years and had experienced multiple transitions across services. The mother had an LD too. His aunt had schizophrenia and the patient had no contact with his father. The patient was attending educational courses in FCAMHS and had expressed an interest in taking college courses in the future. Whilst in FCAMHS he was sectioned under section three of the MHA and had assaulted nursing staff several times. The patient was transferred to an adult medium secure unit specialising in LDs three months after his 18th birthday.

Patient 17

This White British male patient was transferred to FCAMHS from a residential placement he had been for the past three years due to his high-risk-sexaulised behaviour. The patient demonstrated sexual interest in females, children, and animals and child pornography. He did not have a forensic history, but he had a history of exposing himself in public masturbation. He was in high risk of self-harm due to exposure to his own and animal faeces. He was detained under section three of the MHA. He was diagnosed with a mild LD, Asperger's syndrome, conduct disorder, hyperkinetic disorder, and multiple disorders of sexual preference. Whilst in FCAMHS the patient was engaging in psychology sessions and discussed openly about his sexual fantasies with young children. The patient received education for people with special needs and was attending courses for 12th grade. His family did not have a history of mental health problems and the patient was getting along with them. The

patient was happy about his prospect transition and was discharged to an adult medium secure hospital six months after his 18th birthday.

Patient 18

This White British male patient was referred from CAMHS outpatient services to FCAMHS due to his aggressive behaviour towards his mother. He was living at home because he was excluded from a residential boarding school due to aggressive and sexualised behaviour in class, as he was touching staff. He had been bullied and often isolated. His father had alcohol abuse problems and his grandmother had bizarre behaviour and probable LD. There are reports that his father had sexually abused him when he was four years. His father was violent towards his mother and the patient and his brother were exposed to domestic violence. The patient was diagnosed with ASD, mild LD, schizoaffective disorder, and paranoid schizophrenia. He also presented OCD traits. He had tried to hang himself in the past. The patient has a history of assaulting staff whilst in psychiatric units. He was sectioned under section three of the MHA. He had expressed thoughts of killing staff, his mother, the police and members of public. His education had been severely interrupted from childhood due to his mental state. However, he received education whilst in FCAMHS in order to gain accreditation. The patient was discharged to a psychiatric hospital-National Autistic Unit (NAU) a month after his 18th birthday. The patient was not worried about his transition, as his placement was close to his mother and he had been hospitalised there in the past.

Patient 19

This White British male patient was referred to FCAMHS, as he could not managed in the community where he was living with his mother. He exhibited high-risk behaviours and would often put himself in physical risk. The patient was diagnosed with social and specific phobias, mild LD and childhood ASD. He presented with poor social skills and understanding along with social anxiety. He had suicidal thoughts and depression symptoms. The patient was sectioned under section three of the MHA. His

mother had a history of depression and his father of alcohol abuse. The father had also been engaged in criminal activity and had poor social skills and tics. The patient did not have any contact with his father since the age of three years. The mother's parenting had been quite inconsistent, and the patient had been under Child Protection Plan, as she could not manage his behaviour. The patient was home schooled by the mother- at level year two primary school. Whilst in FCAMHS he was attending educational courses according to his developmental level (ASD). In the past, the patient had changed about eight schools and had caused severe property damage at one school property resulting in his arrest. The patient was discharged to a locked rehabilitation inpatient setting where they were informed that he needed an individual education plan.

Patient 20

This White British male was referred to FCAMHS from PICU because they could not manage his behaviour. Previously he was in an ASD residential school where again he presented with behavioural problems. The patient was diagnosed with severe LD, childhood ASD, and bipolar affective disorder. He has significant speech and language deficits along with difficulties in communicating his needs. It was suspected that there was a history of depression and psychosis from the father's family. One of his two sisters had language and speech problems. The patient had regular contact with his family including phone calls and visits. There was a history of inappropriate sexualised behaviours involving inappropriate touching behaviours. The patient had exhibited aggressive behaviours towards his parents and had assaulted staff in his previous schools. There was no history of convictions and he was detained under section three of the MHA for treatment. Whilst in FCAMHS, he had assaulted staff and a peer and had been engaging in self-harming. The patient completed some units for AQA Entry level certification in Maths. He was discharged to a residential school and would follow up with Adult LD community services once he turned 18 years, a month after his transition.

Patient 21

This Saudi Arabian female patient was referred to FCAMHS from a low secure unit due to an increasing number of aggressive incidents. The patient was diagnosed with schizoaffective disorder manic type and mild to moderate LD. She exhibited bizarre behaviour in the past and had thoughts that other people are trying to poison her food and kill her. She was sectioned under section three of the MHA for treatment. The patient also had obsessive-compulsive ritualistic behaviours. She had expressed that she would like to live home with her family or somewhere in the community near home. When she visited home for an overnight stay, she presented with threatening behaviour and the police intervened and took her back to FCAMHS. Whilst in FCAMHS she was attending educational courses and was preparing for Functional Skills in English at Entry Level two. She was placed on an adolescent ward and had to transition to adult services but was waiting for assessment from her local services. She discharged herself against medical advice when she was 20 years to Early Intervention Services (EIS). The clinicians had stated that she was unwell and could not live independently. She was presenting high-risk and aggressive behaviour and refused to take her medication.

Patient 22

This Black British male patient was initially referred to FCAMHS from a psychiatric hospital due to deterioration of his mental state and aggressive behaviour. However, he was discharged back home, and after a few days readmitted to FCAMHS, as his psychotic symptoms were exacerbating. The patient was diagnosed with schizoaffective disorder, mild to moderate LD, and conduct disorder. He believed that members of staff had raped him, and his family was killed by FCAMHS. The patient had experienced domestic violence (father to mother). His father had an extensive criminal background and upon his visits in FCAMHS, he had threatened to kill his son's responsible clinician (RC) and then he was forbidden of visiting his child. The patient's maternal aunt had a history of depression and his paternal aunt was diagnosed with bipolar disorder. His uncle had also a criminal history. The patient had a twin brother who had been in FCAMHS due to his mental illness that was psychosis and violent behaviour. His

sister was involved in YOT because she had a history of offending including robbery and assaults. The patient had been convicted of 23 offences that were primarily violent. He had also assaulted severely a member of staff in FCAMHS and was charged. The patient was detained under section three of the MHA. The patient had expressed that he would like to go to college when discharged. He was discharged back home to community LD services one month before his 18th birthday. He could not be discharged earlier due to lack of bed availability from receiving services.

Patient 23

This White British male was transferred from court under section 37 of the MHA to FCAMHS. He was charged with criminal damage to property, arson, and theft. He also had a history of inappropriate sexual behaviour, animal cruelty, and had stabbed his brother. The patient was diagnosed with schizoaffective disorder, mild LD, and conduct disorder. When he was a child, he received a formal ADHD diagnosis from CAMHS. His mother had a history of depression and he had never met with his biological father. There were allegations that a neighbour had sexually abused the patient. He had been involved in a gang and was very vulnerable to his antisocial peers. He had been bullied at school and in previous wards. He received remedial education, whilst in FCAMHS. The patient had been using illicit drugs and, mostly cannabis from the age of 10 years. Previous attempts were made to discharge him to community placements before turning 18 years. However, the patient was worried about this prospect transitions and behaved aggressively in order to remain in FCAMHS. He was transferred to a structured community LD placement three weeks before his 18th birthday when a local AMHS team would take over his care.

Patient 24

This Black British male was transferred to FCAMHS from an STC under section 48/49 of the MHA, as he had his first psychotic episode. He had suicidal ideation while in prison and had been extremely suspicious and

paranoid with irritable mood. He exhibited bizarre behaviours and would not be responsive to casual conversations. He was diagnosed with schizoaffective disorder. The patient had speech and language difficulties. He was charged with robbery and cannabis possession and had breached his bail order. The patient had been aggressive towards his mother to the point the police had to intervene. He had experienced domestic violence, as a child, where his father was aggressive towards his mother. He had no contact with his biological father. The mother had mental health difficulties. There were concerns that his mother had psychotic illness and she also had anxiety problems, panic attacks, and low mood. His uncle had a criminal history and had been in custody. The patient was expelled from college permanently after he attacked to another student. However, no educational records were found. He was discharged to community EIS.

Patient 25

This Black British male patient was transferred to FCAMHS from a PICU, five days after admission, due to his paranoid thoughts and aggressive behaviour. He had been hospitalised in the same forensic inpatient unit in the past and he was discharged successfully. The patient was diagnosed with psychosis and had racing thoughts was suspicious towards others including his family. He had an extensive forensic history of carrying a weapon and cannabis and was sectioned under section three of the MHA. His family was very much involved in his treatment plan and issues with parents were addressed. His mother had attachment issues in terms of helping her son to become independent. She was breastfeeding him until 3 years. The patient reported that he was afraid his mother would perceive his independence as abandoning and rejecting her. He was also very inpatient in regard to his prospect transition to community. However, his transition was a slow progress with frequent home visits and family therapy. He returned home two months after his 18th birthday and was followed up by EIS. The patient was attending a college plumbing course.

Patient 26

This Black British male patient was admitted to FCAMHS from an inpatient hospital due to his psychotic symptoms and aggressive behaviour towards members of staff. The patient had psychotic illness including visual and auditory hallucinations. He had expressive language difficulties. Prior to hospital admission he had assaulted his father that did not result in any injury. Before this incident his mental health was deteriorating for over a month displaying aggressive and agitating behaviour. He was detained under section three of the MHA. Whilst in FCAMHS he had assaulted staff many times verbally and physically. He had been bullied on the ward and one peer assaulted the patient physically. He was engaging well in education but had failed his GCSEs and wanted to go to college after he would be discharged. His family was involved in his care, but he preferred his father to visit him and had expressed that he did not wish his mother to visit him. The patient was discharged back home soon after his 18th birthday followed up by EIS.

Patient 27

This Black African male patient was referred to FCAMHS from YOI due to his psychotic symptoms, paranoid thoughts, and bizarre behaviour. The patient had reported that he had spent 22 hours in his cell whilst in custody. He was charged for robbery and was carrying a bladed article and was sentence for three years. He was sectioned under 47/49 of the MHA. The patient had assaulted his mother in the past and, therefore placed with a foster family and next in an independent placement. Frequently he expressed anger towards his father because he had extramarital affairs. The patient described a “very good childhood.” They moved to the UK when the patient was seven years from southern Africa. The patient was diagnosed with psychosis and had been using cannabis since he had been 12 years. He was addicted to stimulant drugs and had committed robbery under the influence. He was also involved in the local gang culture. The patient attended school until 11th grade and then a Multi-skills course in college. He was described as a *charismatic* boy with excellent music skills. The patient returned to prison.

Patient 28

This White British male patient was transferred to FCAMHS from an adult PICU due to his paranoid thoughts and aggressiveness. The patient was diagnosed with paranoid schizophrenia with auditory and visual hallucinations. He had a long history of cannabis misuse. It was suspected that he had a learning disability, but assessment was pending. He had been engaging in self-harming too. The patient had also an extensive forensic history of 18 convictions for 44 offences including assaults, theft, burglary, and property damage. He was sectioned under section three of the MHA. He had been neglected, physically and emotionally abused, as a child and had experienced domestic violence between his parents and they both were abusing alcohol. One of his half-sisters had died recently. The patient was raised in an unstable environment where he was moving homes and his basic needs were inadequately met. Social Services had been involved with the family for many years. Whilst in FCAMHS he had initiated a number of incidents being violent (assaulting members of staff) and the police had to intervene. He needed a personal education plan and was engaging very well in music classes. The patient was discharged to an adult medium secure unit a month after his 18th birthday.

Patient 29

This White British male patient was admitted to FCAMHS from an adolescent PICU/LSU due to his manic symptoms including agitation, elated mood, openly masturbating, and being aggressive towards staff. He had a long history of cannabis use. He was sectioned under section three of the MHA. He had a forensic history of assaults, burglary, and theft. He had also assaulted seriously his father and threatened him with a knife in the past. The patient had Asperger's syndrome, anxiety and depressive disorder and was diagnosed in FCAMHS with psychotic illness with manic symptoms. He believed he had special capabilities staff members were jealous of. The patient has been accommodated in several residential placements and foster care homes, because the situation home was chaotic. However, before his hospitalisation, the patient was staying with his father and brother. His mother was involved in his care. The patient did

not engage in any education whilst in FCAMHS but attended music classes that he enjoyed. The patient was discharged to a community placement a month after his 18th birthday. Before his discharge he had been extremely stressed, as he was fixated on it and was becoming significantly frustrated whilst waiting for his transition. The patient was not given a discharge date and that impacted his mental health.

Patient 30

This White British male patient was transferred to FCAMHS from a psychiatric hospital due to his aggressive behaviour and psychotic symptoms. He was in a SCH before because he had assaulted on his mother. The patient had experienced domestic violence between his parents. The mother had an alcohol abuse problem and so had developed the patient. The mother had also suicidal thoughts and was hospitalised. Therefore, he was under the care of the community alcohol team. The patient had a learning disability along with ADHD. He was also diagnosed with psychotic illness but did not present any visual or auditory hallucinations. However, he had delusions about staff urinating in his food. The patient had been smoking cannabis since he was 12 years. He was sectioned under section three of the MHA. He had a forensic history of assaults and had assaulted staff and peers in the ward. He had been excluded from an Art's College due to his inappropriate behaviour. Whilst in FCAMHS he was attending college and had expressed he would like to become a football coach. He was discharged to a shared LD community accommodation seven months after his 18th birthday. Before his discharge he appeared frustrated whilst waiting.

Patient 31

This White British male patient was transferred to FCAMHS from YOI due to the deterioration of his mental health symptoms, mostly, self-harm and auditory hallucinations. The patient was experiencing command hallucinations telling him to kill himself. He was diagnosed with psychosis, PTSD, and emerging BPD. There is a history of psychotic illness in the family. He had flashbacks from being abused and attachment problems.

The patient had low mood and hopelessness and constant suicidal thoughts. Whilst in FCAMHS he had assaults on peers and members of staff and had been engaged in self-harming behaviours such as swallowing items. He had also a long history of substance abuse. He was detained under notional 37 of the MHA. In the past he had been convicted of a sexual assault against a young girl. His older brother had sexually abused the patient when he was four years. Both his brothers had a forensic history and had been in custody. He had experienced domestic violence between his parents and his father had a lengthy custodial sentence. The patient was not engaged in education much due to his symptoms. His family had been visiting him quite regularly. The patient was discharged to an adult medium secure unit a few months after his 18th birthday.

Patient 32

This White British male patient was referred to FCAMHS from a YOI due to his psychotic symptoms. The patient was diagnosed with paranoid schizophrenia and had auditory and visual hallucinations along with olfactory and tactile and a range of negative symptoms such as flat mood and withdrawal He had tried to abscond through the window whilst in FCAMHS. The patient was detained under Section 47/49 of the MHA and he had committed two violent robberies. He was charged for attempting to murder an elderly man by stabbing him multiple times. He has a long forensic history of assaults, arson, battery, property damage, biting a prison officer, and attacking nurses with a plug attached to a wire. The patient had been using drugs such as cannabis and cocaine since he was 7 years. Initially the patient was referred to an adult medium secure unit but then it deemed that an adult high secure environment would be more appropriate in his case. He was transferred to an adult high secure unit two weeks before his 18th birthday due to his deteriorating mental health and high-risk. It is highly uncommon to admit patient under 18 years in high secure hospitals but in this case, it was necessary and there was no alternative. The patient was very close to 18 years and there were no issues on his vulnerability.

7.4 Discussion

This study aimed to examine the complexities and multiple needs of young people discharged from FCAMHS to adult and community settings between May 2015 and June 2016. I included a nationwide sample from all nationally funded FCAMHS in England and retrieved case notes from all services. This study looked at the annual transition numbers and transitional pathways including previous and future placements. The clinical characteristics alongside abuse histories of these young people illustrate the complexity of their needs based on similar backgrounds.

7.4.1 Case vignettes

The above vignettes present the background histories of 32 young people. All case note reviews share similar characteristics in terms of life risk factors, mental health problems and transitional pathways. However, each case differs in terms of index offence and number of offences and distinct transitional pathways in adult mental health care. Some cases were *typical* and other *deviant* regarding clinical and transition characteristics (Crowe *et al.,* 2011). For instance, most patients were detained under section three of the Mental Health Act. Yet, only patient 3 had a diagnosis of Body Dysmorphic Disorder and patient 32 was the only one to be transferred to an adult high secure hospital before his 18th birthday. The literature does not provide much knowledge about young people in FCAMHS with eating disorders and current CAMHS do not accept young people with eating disorders as primary diagnoses (Singh *et al.,* 2010). Majority had experienced a form of loss and trauma either by having a parent in prison, or a parental figure absent from their lives, or a family figure being abusive.

Findings show that sexual offending is linked to poor attachment styles in early childhood (Marshall *et al.,* 1993). Males nurtured within insecure attachment styles tend to have low self-esteem and seek this

form of confidence through forced sexual behaviour. All young people shared similarities in their backgrounds: mother and/or father with depression or schizophrenia, sexual and/or physical abuse. Parents with mental health problems find it difficult to form bonding relationships with their children and the latter are in risk of experiencing emotional neglect and/or abuse.

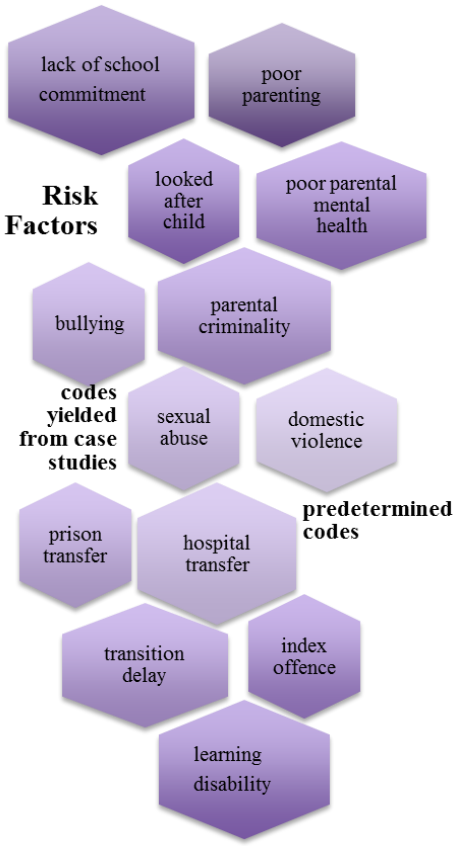
Previous research has revealed that adolescent sex offenders are more likely to be socially isolated, to come from dysfunctional families and to have experienced parental rejection (Marshall *et al.,* 1993). The results from the current study may corroborate past findings if we consider the inconsistent parenting styles they have experienced based on poor parental mental health and being LAC. However, there are differences in sexualised behaviour between males and females. In the current sample, only males had a sexual offence whilst one female presented with sexualised behaviour towards staff (patient 3). Those young peoples' families exhibited severe signs of social marginalisation given past parental criminality and contact with social care services and, therefore, might have aggravated later feelings of personal and social isolation experienced by the young people. Sexual offending and sexualised behaviour demonstrate a difficulty in developing intimacy and forming relationships underlined by attachment. Yet, half of the young people had experienced a sort of abuse and/or had a parent with a mental health problem and they committed another index offence. Therefore, there might be other developmental components or personal and biological attributes that we lack information about.

It is quite established in the extant literature that the presence of multiple risk factors in children's and adolescent's lives such as abuse, bullying, poor parental mental health, increase the risk for offending behaviours (Valois *et al.,* 2002). Some themes were predetermined such as diagnosis and transitional pathway. Yet, sexual abuse and parental mental were themes in the case studies. Whilst there is evidence that sexual abuse and/or parental mental health are linked to

poor mental health and violent behaviour, I did not make presumptions regarding this sample's risk factors.

About 19% (6) had been bullied in primary school and isolated as children. Five of them had ASD and/or a learning disability and four were self-harming and had attempted suicide in the past, presented with sexualised behaviour and three were victims of sexual abuse. Bullying has been associated with offending and could contribute to poor mental health. Research findings have shown that victims of bullying are more likely to depression, anxiety and withdrawal, and suicidal ideation, being sexually and emotionally abused, and experienced bad parenting (Nickerson *et al.,* 2014).

Figure 15. Themes and codes predetermined and generated from case studies



Males are more represented in FCAMHS and existing data show that males are more prone to aggressive behaviour that is in line with

psychosocial norms. Yet, it is evident that the female cases present with the same severity of symptoms and, at times with more aggressive behaviour and more complex needs. It should be noted though that forensic services and the criminal justice system is more used to deal with male offenders either juveniles or adults and the needs and presentations of female offenders might be overlooked (Hoyt and Sherer, 1998). Some research suggests that female offenders may identify with the same sex parent, so daughters may identify with their mothers having mental disorders. The eight young female patients in this study had experienced poor attachment in early childhood and six of them had a mother with a mental disorder including substance abuse. Patient 1 whose mother did not had any known mental disorder had been sexually abused in the past-it was not known who the perpetrator was. Patient 21 was a very unique and atypical case of a young woman discharged from FACMHS when she was 20 years old. No much information existed about her family background but she was violent when she was around them. This patient was resistant to treatment and did not engage with clinicians. However, she did not wish to leave FCAMHS. Presumably, this type of patients have stayed long in secure services and institutionalisation may have turned into their normal routine. Young female offenders also present with attachment difficulties similar to patients 2 and 3, where transition becomes a challenging and anxiety-provoking experience. These young people may become attached to healthcare professionals, who may be the first consistent figures in the young peoples' lives providing care. Patient 7 had experienced loss due to her brother's death and refused to eat, which could be seen as a form of bereavement. All eight female patients presented with very difficult to manage risk behaviour whilst patients 1, 2 and 4 had been sexually abused and patients 2 and 3 had been bullied in school. Five had PTSD, all presented with severe self-harming, and six had emerging BPD that could explain emotional dysregulation and self-injuring incidents.

Family factors also might have accounted for offending. One study comparing youth in community settings to those in contact with the criminal justice system found higher rates of family disruption and childhood maltreatment in the second group (Duran-Bonavila *et al.,* 2017). Majority of these young people have been exposed to early trauma and violence and had experienced imprisoned parents, broken homes, sexual abuse and/or neglect from family members. The extant literature has established a major link between parental criminality and child abuse and future violence (Valois *et al.,* 2002). Patient 10 had ended up in social care due to her mother's imprisonment and also had experienced abuse from her biological mother and stepfather. This female patient had comorbid mental health problems and neurodevelopmental disorders and a strong history of self-harming. Her first life relationships were characterised by lack of attachment and disruptive family environments. Patient 3 presented with multiple mental health needs and an atypical mental disorder in forensic adolescent inpatient services. She also had sexually inappropriate behaviour and it may be assumed that her autistic traits intensified this type of behaviour. The fact that her mother had post-natal depression could be seen as additional trauma experiencing parental rejection from very early years. Her antisocial behaviour was primarily manifested towards her family, which is quite typical in this forensic sample.

Patients 1 and 2 had parents with mental health problems. Patient one had not established a bonding relationship with her mother due to the latter's mental health difficulties. Poor parental mental health seems to interfere with young people's psychosocial development and impede attachment at an early age. Patient 6 had been sexually assaulted multiple times in the past and his mother had schizoaffective disorder as he did. Research suggests that violent behaviour is learnt through conditioning and, therefore young people often re-enact this pattern of violence through offending (Valois *et al.,* 2002).

Half of the young people involved in the case notes had experienced multiple moves and transitions across services, foster care, carers, and mental health services. Multiple moves in childhood are associated with violent behaviour, as they heighten instability in young people's lives and provide one more aggravating factor to poor attachment to communities, placements and schools (Valois *et al.,* 2002).

7.4.2 Age at time of discharge

The findings suggest that the age transition boundary across national services varies between 18 and 19 years. The national policy inquires that young people need to 18 and over to be accepted by adult services. However, most of the young people were not discharged according to the established age transition boundary corroborating its ineffective character during the transition process. The age at the time of transition depends highly on bed availability at the receiving services, collaboration between and across services and commissioning sources. Some young people moved to adult services a few weeks before their 18th birthday because they could not be managed at FCAMHS or there was additional pressure from commissioners and local authorities. Yet, it is known that adult services would not accept any young person before they are legally considered an adult. Adhering to rigid age criteria does not serve any purpose across services since standard procedures are not followed considering long delays to be transferred to forensic adult hospitals. Handover might not be timely along with liaison between services and shortage of beds in forensic inpatient hospitals.

7.4.3 Transition pathways

Majority of the young people were transferred to FCAMHS from prison and psychiatric hospitals. Dimond and Chiweda (2011) reported that 70% of the young people transferred to the Wells unit were from YOIs. However, only a few returned to prison settings and many of them were discharged to community placements and forensic medium secure hospitals. Those admitted to FCAMHS from a psychiatric hospital were

again referred to community accommodations and forensic medium secure hospitals.

Psychosis manifests with much more severe symptoms than other mental health problems. Hence, incarcerated young people with milder symptoms and different mental disorders might remain in prison settings since their symptoms might be missed. Young people have to present with high-risk alongside a mental disorder to be liable for detention under the Mental Health Act. For instance, young people whose primary diagnosis is a learning disability or possibly a neurodevelopmental disorder would not be eligible for care and treatment in FCAMHS while they might be presenting with high risk. Young people with severe self-harming behaviour and suicide risk would be more likely their symptoms to be unrecognized in prison settings. Accordingly, the severity of the mental disorder would determine young people's care pathway. As Willow emphasises (2015):

"Only those with very serious mental health disorders are moved to hospitals, but only after they are sectioned under the Mental Health Act and the approval of the secretary of state for justice…has been granted." (p. 53)

Patient 32 had been in an adolescent prison before moving to FCAMHS and then was transferred to a high secure hospital. This case is atypical for several reasons. First, adult services are not meant to accept young people before they turn legally 18 years, but they made an exception. It looked like FCAMHS had to displace the responsibility onto another service as quickly as possible because they could not manage the patient's risk. This could have occurred due to safeguarding issues on the ward e.g. the patient's behaviour might be threatening to younger patients. However, this young person might not be suitable for an adult high secure environment either. High secure hospitals accommodate adults with long forensic histories and those who present with the highest risk and most notorious offences. Yet, majority of this

population has been in high security for several years with average stay eight years. This young patient stepped up security level solely based on his risk and not his needs. Interestingly enough, his records about his childhood and family backgrounds were incomplete.

7.4.4 Length of stay and continuity of care

Length of stay in FCAMHS varied widely across the group. However, majority of the young people would stay roughly for two years in forensic child services. Dimond and Chiweda (2011) refer to *relational security* as an essential element on building relationships between forensic mental health professionals and patients. FCAMHS aim to form robust relationships based on rapport and trust in order to build therapeutic alliance and work though therapeutic interventions. Yet, these secure relationships are lost once young people move to adult services. FCAMHS are highly supportive and structured environments to provide containment for young people (Dimond and Chiweda, 2011). On the other hand, adult mental health services have different goals and take into granted that young people once they have turned 18 years are ready for more independence whereas daily planned interventions are not necessary. Hence, the transition from FCAMHS to adult services' philosophy poses young people in risk to re-experience trauma and loss.

Continuity of care was different among the group where most of the young people were discharged to community placements and some of them to secure hospitals whilst a few returned to prison. The fact that 13 out of the 32 young people moved to community placements in spite of their strong forensic histories and high risk shows that healthcare professionals aim to reintegration into the community. Living in community settings could be quite challenging for this group of young people in terms of managing daily life, mental health problems, education and/or employment, and aggression. In case, the discharge process to community is not well prepared and managed by the multidisciplinary team (MDT), the young person's transition might bring

poor outcomes and worsen risk presentation (Dimond and Chiweda, 2011). Transitions to community can be very sensitive and clinicians' decisions involve risk to a certain extent. The Wells Unit reports that young people transitioning to the community might need additional support during that critical period and, therefore, they would follow them up by attending their Care Programme Approach (CPA) meeting at the new placement.

Yet, 25% of the young people moved to adult medium secure hospitals from where a step down to lower security services would be less timely and would extend their stay within forensic services. Adult placement depended on risk and not particularly to the diagnosis. About 50% of those with a psychosis or schizoaffective disorder diagnosis were transferred to a community placement. The other half with those diagnoses was moved to different levels of forensic adult hospitals. Clinical decisions about the young person's adult placement differ among clinical teams in different hospitals and in this sample it was evident that the Wells Unit would only discharge people to community settings.

7.4.5 Clinical characteristics of young people

Psychosis was the most prevalent mental disorder in this sample of young people. Learning disabilities rates were quite high along with PTSD and self-harming symptoms. Previous research has illustrated that psychosis is more prevalent among males than females and, similarly, males outnumbered females in the current sample. Three of the hospitals would admit only males and only two hospitals accommodated young female patients. However, majority of the sample presented with psychiatric comorbidity that is in conjunction with the existing literature (Lader *et al.,* 2003). A national UK study including young people 16 to 20 years had found that at least 80% of the sample had two mental health problems. The young people in the current study were accommodated in secure adolescent inpatient services, which would explain the complexity of their mental health symptoms.

Self-harming was evident in both sexes and integral of most young people's developmental history. Males were engaged in self-harming behaviour as much as females in the current sample. Research findings show that mentally disordered adolescent offenders in detention have lower self-harming rates than females. Yet, the results from this study could be explained due to the difference in settings and presentation of mental health problems and histories, which are much more severe and complex.Patient 1 presented with severe self-harming that is common for female offenders and comorbid mental health disorders and neurodevelopmental problems that can explain her violent behaviour. She presented with delinquent antisocial behaviour such as fire setting and had been in a secure establishment due to her offence. The patient had experienced sexual abuse, and this was linked to her PTSD symptoms. She was moved to the community despite her multiple needs based on risk presentation at the time of discharge. Yet, this young person had multiple and complex needs that would need to be addressed in community follow-up by providing ongoing support.

Autism was prevalent in this group including Asperger's syndrome. Previous research has revealed that adult mental health services lack proper care to meet the specialised needs of this group due to lack of available based treatments and trained staff (Signorini et al., 2017). However, this group of young people receives mental health care due to the presence of other comorbid mental health problems. It remains debatable though whether their neurodevelopmental needs are properly addressed. Previous research has highlighted that those young people with neurodevelopmental problems, learning disabilities and emerging personality disorders are those in risk of falling in the services' gap (Lamb and Murphy, 2013). Whilst young people moving from FCAMHS receive continuity of care in adult mental health services either in secure hospital or in community placements due to the mandatory Aftercare Mental Health Act section, we should question the quality of

care they receive. The idea of having a comorbid-usually severe mental disorder-mental health problem to be accepted is quite problematic. Considerably, their neurodevelopmental needs or emerging personality disorders might not be addressed.

High PTSD rates could be explained by the traumatic experiences embedded in these young people's backgrounds including community, family, and/or personal factors (Young Minds, 2013). Half of the sample had experienced sexual abuse or witnessed domestic violence during their childhood. Developmental trauma has been integral in most of these young people's lives whereas loss and abuse heightened their trajectory (Dimond and Chiweda, 2011). These young people have experienced relationships lacking in attachment that augmented their mental health symptoms. Research findings suggest that lack of family attachment and inconsistent care giving is a risk factor to youth's mental health (Patel *et al.,* 2007). Some young people had been LAC, which is in line with Beyond Youth Custody (2013) reports about detained children. These young people had experienced inconsistent parenting, multiple transitions in foster homes, and social services involvement in their care. Some had one parent in prison and had also been exposed to violence.

7.4.6 Educational needs

All young people who attend FCAMHS receive educational core courses depending on their level and needs based on educational assessment conducted by the education team. Majority has not been in education before or has failed to commit to school attendance and their mental health difficulties impact on their education ability (Dimond and Chiweda, 2011). Therefore, they are being offered a wide range of courses, from English and Math to Cooking and Music, where they can explore their preferences and inclinations. However, this educational model changes as they move onto adult mental health services.

Child services have different policy and commissioning plans that affect the education of young people. Lamb and Murphy (2013)

reported that in England and Wales child mental health services policy is connected to the Education Department. Yet, this is not the case for adult mental health services. Many of these young people have a structured routine including educational courses on a daily basis as long as they are in inpatient FCAMHS. Once they move to forensic adult services, this structure is lost along with mandatory education. In the current sample, only one young person moved to an educational residential facility. The number of such placements in young people's catchment areas alongside the funding might be limited. Young people with neurodevelopmental disorders and intellectual disabilities have much more complex and individualised educational needs that are often not met in adult mental health services.

Accordingly, young people may find that their educational level has improved whilst in FCAMHS. Once they move to adult services their efforts are lost in the system's gaps. Even if young people have completed core education during their stay in FCAMHS, they might need additional vocational training to prepare for future community transitions. Targeting employment skills and vocational training would help young people towards a more independent style of living in the community based on structure and desistance from reoffending and relapsing.

7.5 Strengths and Limitations

I encountered major challenges and difficulties in finding and accessing the medical records of these young people. Personal and mental health records of young people in forensic services comprise highly sensitive information. The process duration depended on each site and how quickly they responded to my inquiries. I had to send multiple emails to the local collaborators, their secretaries, and administrative staff. One site was visited about seven times to access the case notes electronically. Another site did not have a central database to access information for discharged patients and after having received training the local collaborator provided the information about the discharged

patients. In sites where I had electronic access many of the patients' forms were not completed and, therefore important information was missing either regarding their family background or education. All sites were out of my geographical area so most times I had to travel about three to four hours to reach the sites. All sites use computerized record systems such as RiO and PARIS that required extra training days at each site separately.

The annual cohort moving from FCAMHS to adult services between May 2015 and June 2016 was small. Yet, the numbers of young people admitted to FCAMHS is low and the study's sample represents national data from all six inpatient FCAMHS across England. Accordingly, the sample should be considered representative of this particular group of young offenders accommodated in secure adolescent inpatient services. For instance, the Wells Unit admitted 55 people between 2006 and 2011 (Dimond and Chiweda, 2011). For the purposes of this study eligible participants were only those reached or crossed the age transition boundary to move to adult services. The caseload in inpatient FCAMHS differs significantly from those in inpatient CAMHS, as those admitted to FCAMHS compose a very distinct group of young people presenting with high risk and forensic histories. Consequently, the sample is generalisable to the population of transitions to adult and community setting from all nationally commissioned adolescent inpatient services in England and Wales.

The cross-case and documentary analysis were chosen very carefully taking into consideration the limited detail of qualitative analysis. Therefore, the information provided for each case was studied and explored in-depth and narratives and variables were created to give meaning to the cases.

7.6 Conclusions

This study added important findings to the existing literature by including 32 case studies of those young people who were discharged

from all FCAMHS to adult services, prison and the community between 2015 and 2016. This case note review constituted national data that revealed the demographic and clinical characteristics of young people eligible for transition to adult services due to age national criteria. Comorbid mental health problems alongside neurodevelopmental disorders and/or learning disabilities were present in majority of the cases highlighting the complexity of their needs. Accordingly, there is an expectation that services need a compounding model of care adopting a holistic treatment approach to meet these young people's multitude needs. This study explored each case beyond characteristics and involved family and service background information to obtain a holistic view of each young person's care-pathway. The similarities across cases show that FCAMHS admit a particular cohort of young people who have been in contact with mental health services and the youth justice system from an early age. Yet, transition outcomes differ despite the consistency in family and/or forensic backgrounds amongst young people. Transition outcomes and destinations can be decided depending on presenting needs at the time of transition in terms of risk and mental health presentation. Therefore, young people with the same offence histories and mental disorders can end up in different placements. Yet, need and risk need to be evaluated gradually considering that transition is also an ongoing process. Young people's needs are dynamic and, therefore ongoing assessment and evaluation is necessary to adequately meet these changing needs. Transition destination may not be based on static decisions. Transition destinations varied in this sample from prison settings to forensic adult hospitals. Half of the sample was discharged to community placements and this outcome looks promising in terms of rehabilitation and reintegration to the community. However, those young people presenting with high-risk at the time of discharge, are more likely to move to forensic adult hospitals taking into account lack of readiness to transfer to a more independent environment.

It was difficult to access and retrieve the personal mental health records of these young people and much information was missing, as the relevant paperwork was not completed. The way data are currently organised can lead to inconsistent information that hinders a holistic view of transition outcomes. Clinicians encountered difficulties in retrieving details about referrals and specific dates and for administrative staff it would take in some cases five months to retrieve the cases. Yet, important information was missing about young people's educational needs and historical backgrounds. The current number of cases might be underestimates and it looked like certain records could not be retrieved. The TRACK study encountered the same kinds of difficulties when looking for actual and potential referrals whereas databases did not exist, or information was missing. The report's authors emphasise that the lack of central databases contributes to poor quality services because it impedes commissioners and service providers to understand the magnitude of the transition's problem (Singh *et al.,* 2010). The numbers of discharged young people during the period of May 2015 and June 2016 depended on the numbers and cases identified by the local collaborators and administrative staff. A standard national data collection schema would significantly facilitate this process and provide a clearer overview of forensic child and adolescent mental health care cases. Identifying the characteristics and special circumstances that underline transition processes would overcome the current challenges. The next chapter, which is phase four of this study, extends and builds on the findings of phase two and phase three. Phase four includes semi-structured interviews with young people, their carers and healthcare professionals from forensic child and adolescent mental health services and adult services to explore their transition views and experiences.

8 Exploring the transition experiences of young people, families, and healthcare professionals across forensic child and adolescent mental health services

"The children we lock up in prison are a subsection of a subsection of children really. They constitute the most damaged and disadvantaged of a very damaged and disadvantaged group of people …there is not a single child in custody who comes from what would be regarded as a normal background where the normal nurturing of upbringing goes on."

(Baroness Vivien Stern in Willow, 2015: 25)

8.1 Chapter overview

This chapter focusses on the transition experiences of young people, their families, forensic child and adolescent mental health services (FCAMHS) and adult health care professionals.

8.2 Research question

What are the views and experiences of young people, their carers and healthcare professionals concerning transition process?

8.2.1 Aims

The aims of phase 4 were:

- to bridge the gap in the existing literature by capturing the experiences of young people, families, and healthcare professionals transitioning from all nationally commissioned FCAMHS and receiving adult and community services;
- to understand and reflect on these experiences to enhance current transition of care and improve future outcomes and policy on transitions from FCAMHS;
- to voice young people's experiences as they are moving from child and adolescent secure settings to adult services;

- to adopt a systemic approach in terms of recruiting all the system surrounding young people to gain an in-depth understanding on the transition process and outcomes;
- to check whether young people are central in decision-making during transition process.

This chapter includes qualitative semi-structured interviews with healthcare professionals, young people and their families and carers. The young people were identified with the use of the mapping tool administered to all six forensic child and adolescent mental health services. The local collaborators completed the mapping tool and helped to identify those young people who were eligible to transition to adult services, as they were close to 18 years. The Methods chapter of this thesis includes a detailed section on the methodology, design and the procedures followed for the qualitative interviews. Thirty-four young people were eligible for transition during the period of May 2016 to November 2016. Thirteen young people agreed to take part in this research study and to be followed up and interviewed after they moved to adult mental health services. The interviews with the young people would not be conducted without the use of the mapping tool. Therefore, this study adopted an exporatory sequential mixed methods design, where the mapping tool survey was completed first, and qualitative data followed. Healthcare professionals from adult services were interviewed after young people had been transferred to the receiving unit or community placement. Young people's carers were included in the interviews alongside FCAMHS healthcare providers to gain a holistic view of the young person's transition experiences. All the interviews were thematically analysed with theoretical codes used from the existing literature on transitions and data driven themes selected from the interviews. Reflexivity was used to understand and interpret in-depth the transition experiences of young people, carers and healthcare professionals.

8.3 Results

8.3.1 FCAMHS Healthcare professionals' interviews

8.3.1.1 Transition process

Service transition preparation

All the FCAMHS professionals described the transition preparation, planning and management similarly consisting of the Care Programme Approach (CPA). CPA is an integral and mandatory process during transition times for all young people admitted in FCAMHS. Yet, transition preparation is tailored around each young person's needs and circumstances.

"We use the CPA and that involves the final meeting is a written note according to the Mental Health Act and that is the section 117 meeting. So that's the sort of formal procedure that supports transitions and that ensures that the way that in which the other units have to interact with us, and then other aspects of transition and transfer are to know on individual basis, depending on need and risk." Psychologist 1

Handover planning

The transition process, as explained, is well thought and planned. There is early liaison with the identified adult service discussing thoroughly each case and deciding what is more suitable for the young person.

"The process of preparation each discipline will work with them on a discharge plan, they will work with them on what, it's more about their communication. They will have a communication folder that describes who they are, what are the risk concerns, what they like and what they don't like, what are the things they worked through and what are the things they need to work through, so that's for them to take along with them." Psychiatrist 1

Young people preparation

One of the units adopts a relational model that is based on the family systemic model engaging the family of the young persons to help these patients throughout their care pathway and also to aid their

reintegration to the community. This unit incorporates the parallel care pathway to motivate young persons for their efforts; the patients see parallel care as a 'reward' to engage in therapy and treatment.

"When young people come to us they are aware that our service is designed for 12 to 18 year olds. So that's established to begin with. So we have that discussion early on so they know that the part of getting support from us is planning how they can maintain their recovery and continue the gains they have made when they are actually part of the community. I think rather than breaking relationships it is allowing clear communication from the start that the work that we can do with the young person is limited. But also reassuring them that there is scope for ongoing support and the earlier that we start that the better." Psychologist 2

8.3.1.2 Transition barriers and challenges

Therapeutic relationships with staff

This healthcare professional along with others pointed out to the difficulty of services to engage and motivate young people who know from the very beginning that they will be moving to other services and they do not really think it is meaningful to participate in therapy and/or in educational courses since education is mandatory until their 18th birthday. Two of the units usually accept people who are very close to 18 years-their birthday might be within a three-month period. The fact that this cohort of patients is transferred to FCAMHS just a few months ahead of a forthcoming additional transition to adult services interferes with establishing a proper therapeutic relationship and rapport with the patient. Most patients are aware for their short stay and they are not keen to collaborate with the local clinicians.

"*We have a lot of young people who are admitted to the service relatively late at 17.5 plus and is very difficult to meet their needs when suddenly they are on their 18th birthday and just started to engaging in formal treatment and make relationships with staff and the pressure is moving them to another service, I think what this inevitably does is extending their stay in hospital.*" Psychiatrist 2

Services infrastructural barriers

Waiting time to discharge

Almost all FCAMHS workers referred to the difficulty of young people to cope with transition delays and the adverse effects of this long waiting. A few clinicians mentioned examples where the young person had to be referred to a higher level of security unit because they were not eligible anymore for lower security services and they would not accept them due to risk escalation. Transition delays increased uncertainty and anxiety and were described as a frustrating experience for any young person. The element of the unknown embedded in these transitions triggered violent behaviour and relapse. Young people might end up in seclusion because of violent incidents on the ward.

"*Well, they can be a source of significant anxiety. What I would say is that certainly the uncertainty around what we typically see and we looked in the medium secure group is that prior to transitions, peoples' Honosca scores go up and it's very unsettling times for young people. And there's the risk particularly if you got a comorbid mental illness that the stress can make that illness relapse. And we've certainly seen that happen occasionally even when people get quite a lot of support around the process*." Psychiatrist 3

Bed delays in forensic adult inpatient services

Young people who have turned 18 years and are waiting for a bed to be released in forensic adult hospitals experience frustration remaining in child services. They start disengaging from education and/or psychology sessions and affect the ward's dynamics. There is a split between the younger and the older adolescents on the ward whilst the former are seen as 'kids.'

"So X, he's 18, and was accepted by an adult secure hospital, sometime ago, but they don't have a bed. It's completely clocked up the system. So he's waiting and that is very bad for him. He was offered, said he was suitable maybe two months ago, and we had a CPA last week and they don't have a bed. The system clocked up and they can't tell us when a bed may be available and we have serious problems for X because he started disengaging from our service. He's sort of frustrated that he's still here with the kids, as he reasons. So yes he's sort of stuck at the moment until a bed comes up." Psychiatrist 4

Uncertainty in transition destination

The element of uncertainty impacts the therapeutic relationship between staff and young people and increases disengagement and anxiety. Both parties know that the young person must move onto adult services because they are approaching or have reached 18 years and their therapeutic relationship will be ending soon. Not knowing the exact timing impedes a smooth ending that might enhance better stability placement in the receiving service.

"*The extended period of time, especially, when we don't have an end date, because the patient becomes very demoralised and destabilised. In fact, the nursing staff, the whole team becomes kind of desponded about. You know they need to move on, we've done as much as we can…and you can have aberrant behaviours re*-emerging stuff. When they *don't know when they're going that causes the most problems*." Psychiatrist 5

Mental health symptoms worsening

Young people's mental health symptoms often worsen during transition periods and, especially when they do not know where and when they are leaving.

"*There's a lot of people who relapsed they got to the point they were ready for discharge but it took that long that they ended up back to square one; they relapsed*." Nurse 1

Geographical location

FCAMHS are national services offering mental health provision for young people across the country and, at times having patients from Scotland when appropriate services are not available for this group of young people.

FCAMHS take over the responsibility of the young person for as long as they are accommodated in the inpatient unit. When young people have to transition to adult services, the FCAMH unit has to identify an appropriate placement in their catchment area and liaise with their local authorities and commissioners.

"I think being a national service is probably the hardest. Because for us to form links locally are really hard and to understand what are the criteria for local services, is very hard. I think that's the key; the challenge for being a national service and having young people from any part of the country. That's the biggest problem to getting to smooth transitions really." Psychiatrist 6

Family involvement

One parent could not be interviewed, as they had been the trigger for the young person's offence. Many parents were described as having their own mental health difficulties and would not be engaging in their children's care.

"*Some parents have been very abusive to the children and no longer have any contact. Some parents have difficulties of their own, they do the best they can but it's not very good*." Social Worker 1

Safeguarding in FCAMHS

Young people who have reached 18 years and are still in FCAMHS are the oldest on the ward and this often becomes an issue for younger patients who might become subject to bullying and/or assault by their older peers. Therefore, the transition process for the oldest peer to adult services might be expedited.

"Sometimes it doesn't go according to plan…So the NHS England commissioners, referral coordinators, safeguarding leads; if things start to become a risk from a safeguarding point of view, then you have to involve those professionals into helping the transfer become quicker." Psychiatrist 7

Challenges in forensic adult inpatient services

Older peers

When young people move to adult wards and, specifically, to forensic adult inpatient services, they come across a different cultural context than the one in FCAMHS. Almost all of the clinicians both in child and adult services referred to young people being surrounded by older peers, as a major challenge. Young people leaving FCAMHS where they had been the oldest are moving to adult environments where they are the youngest. The culture dynamic in services shifts and impacts young people's well-being.

"*They get so frightened and cowered… then you're going into an adult service where there's going to be people in their 30s and 40s and maybe in their 50s on the same ward. It must be terrifying for the young people and terrifying for the families*." social worker

'*I mean in normal life can they with their grandparents all the time? No, it's difficult. I think it's really challenging*." Psychiatrist 8

Culture shock- CAMHS adult differences

The difference between FCAMHS and forensic adult inpatient units is quite evident and the abrupt transition from a highly supportive environment to a less structured one might result in more poor transition outcomes.

"When people go to from here to inpatient units, I think it's a big shock to the patients because they go from this very nurturing environment where even though is quite chaotic sometimes here, I think it's much more ordered than an adult unit. So we get a lot of our patients smashing things, shouting, crying; they are very emotional. But we can contain that to an environment where is much lower staffing level and there's much larger groups of patients and the patients are not supervised for much longer." Psychiatrist 9

Mental health deterioration

Finding a suitable placement for this complex group of young people has been quoted by almost all healthcare professionals as a great challenge. Community placements would be often reluctant to take over young people presenting with high-risk or those they have committed a notorious offence in their communities. Hence, it becomes difficult to return these young people to their local areas where there would be concerns from the

community and also community placements might not be trained to manage high-risk with such complex forensic histories.

"*The hardest thing is probably finding suitable places for the young people and waiting for beds to open up because we had a couple of occasions where we had a bed and they've been accepted but the young person had relapsed because it took that long and then ended up not being suitable for the placement anymore, so we had to start again*." Nurse 2

Readiness to move onto adult services

The issue of readiness in developmental and emotional level has been quoted several times throughout the interviews. Those healthcare professionals working with young people with learning disabilities and autistic spectrum disorders described this group as being very sensitive to change and as being developmentally much less prepared for transitioning to adult services. Developmental maturity differs from chronological maturity and emotional readiness.

"*I think it's a very tricky situation because just on the previous day of their 18th birthday they were just 17 and the day after they become adults, is there any change overnight? I don't think so. It's a gradual process. I would think there should be an intermediate service, like service for 18 to 25s.*" Psychologist 3

Commissioners' role

One psychiatrist mentioned that their service used to be more flexible regarding transitions and age boundaries and patients could stay up to their 19th birthday but monitoring of local commissioning was devolved after. Some young people often move to forensic adult services whilst a supportive community environment would be a better fit. However, these restrictions have been set up by commissioning and result in young people's prolonged stay in the system, perceived as continuity of care determining a young person's destination. This solution, as the psychiatrist highlighted, is short-term cost-effective whilst in the long run looks like resource waste.

"*It's very difficult, very challenging. It's easier going to an adult hospital from a commissioning point of view. And that also comes out quite a bit that you think of care*

coordinator. There's always a gatekeeping assessment and then it depends on that but usually because it gets so much variable you usually have a quite good idea before they come for the gatekeeping assessment anyway. Care-coordinators you see them getting nervous when you talk about what placement they have in the community, the forensic, and the offending and the risk point of view but also I think it's the logistics and sorting it out." Occupational Therapist

Assessment by adult hospitals

Forensic adult hospitals have to assess young people before accepting them into their services. The assessment process will be delayed until the young person's 18th birthday due to adult services age rigidity criteria.

"They take them when they are ready, which can be anything after their 18th birthday but most adult provisions refuse to have anything to do with anyone under the age of 18. So they won't come and assess anyone if they are still 17 years. So the whole process of transition often can't even begin until they get 18. So then they got assessed, they might not be suitable and so then we got to find a different unit to come and assess. So it can drag on for months and months and months." Psychologist 4

Barrier to discharge

This group of young people present with high-risk behaviour and community placements turn down these young people considering the nature of their offence, difficult to manage behaviours and risk in the community.

"This is a group of patients who are very undesirable for the mental health teams looking after them in the community. Because of their behaviour generally, often there are in places like this because they are behaving in very difficult ways and some of that behaviour is very much likely to be continued in the community. It is much much easier discharging from here to a secure hospital; the process is much more straightforward." Psychiatrist 3

Risk presentation

Visits to the new placement facilitate the transition process but often they are impeded due to the young person's risk presentation.

"When the risk is high, they will be transferred without these visits but they will be provided information about the service…They wouldn't know the date of transfer." Psychiatrist 1

Mental Health Act

A few healthcare professionals pointed out to the negative and challenging aspects embedded in the legislation. Mental Health Act can have a negative impact on the therapeutic relationship between young people and their clinicians.

"I think the tribunal process is important but sometimes it's very stressful for patients. So, if they appeal against a section, the tribunal is quite a formal thing in the court, how long they've been in hospital for, they are a stressful experience for the patient. The consultant, the Responsible Clinician, has to argue for the continued detention of the patient and, usually, the patient is asking to take them off the section. So, it can become quite adversarial, it can worsen the relationship between the consultant and the patient." Psychiatrist 5

8.3.1.3 Transition success factors

More than half of the FCAMHS professionals identified the Mental Health Act as a protective factor for young people's continuity of care.

"The Mental Health Act is useful-you got to discharge them and you still have treatment obligations carried out, which means they are assured to get follow up. I can't think of a situation, where I said God I have to detain them under the Act." Psychiatrist 7

Extended 17 leave

The Aftercare section ensures that young people will be provided mental health service provision. Extended 117 leave was addressed as facilitating transitions to community placements.

"All the young people are under the Mental Health Act so they're all depending on which section they are on but they all have to be discharged from a section of the Mental Health Act conditionally. Most of them have got an entitlement to Aftercare under section 117. I guess on the whole the Mental Health Act plays a positive role, probably. It gives young people that are very restricted and being looked after, in some sense, it gives them some

protections in that and some rights and it does give them some follow-up entitlement." Family Therapist 1

Local services involvement

Involving local services from the young person's catchment area was identified as a protective factor to transitions. Majority of healthcare professionals mentioned that early communication with a key contact from local services facilitated transitions.

"If you got a good care-coordinator and if you are linked with local services from the onset, that really helps." Psychologist 4

Family and young person involvement

Family composes a protective factor to successful transitions. It is very helpful for people who have a system around them and they have families/carers to involve them in the transition process from early on.

"Definitely involving the system, involving the family, involving the young person in the transition." Family Therapist 2

Another healthcare professional referred to the services offered to help families stay involved:

"We do have family therapy, we do welcome meetings, we do open days for the parents to get them engaged and to give them more understanding and more help." Psychiatrist 2

Education

Education was referred as a protective and facilitating factor for successful transitions in the community. When FCAMHS healthcare professionals aimed to discharge young people into community placements, they would try to embed education in the discharge plan to avoid return to inpatient services.

"I think linking the young person in with other systems, like, for example, education having them linked with college, always helps with the sense of stability in the community and

reduces the likelihood that they will reengage in antisocial behaviour. It gives them more support and structure around them, more meaningful activities." Nurse 2

Table 19. Higher-order themes and subthemes from interviews with healthcare professionals

Themes	Codes	Subthemes	Conclusions
Transition process	Young people preparation	Conversations with Young People	Producing a plan with the young person and their key worker in FCAMHS is the desirable goal for most services. Young people are informed from the very beginning-usually at admission point-that they will have to leave FCAMHS once they turn 18 years.
	Service preparation	Care Programme Approach	All national services carried out an Aftercare CPA meeting before young people's discharge and they all reported aiming to be involving receiving services and family when possible.
		Handover planning	Handover planning is common including preparation and management of transitions involving multiagency working, but the outcomes vary across services.
		Liaising with receiving service	Liaison with receiving services depends on adult service availability to engage. Each staff member of the MDT is aimed to work together with the same type of professional from the receiving service to gain an understanding of the young person's needs.

	Transition placement	Forensic inpatient services, community placement, home, custody	Transition placement determined transition processes and outcomes. Very high-risk cases likely to abscond are not informed about the transition date.
Transition barriers	Emotional barriers	Readiness, developmental needs, attachment to old placement	Emotional barriers were based on attachment to key workers and readiness of the young person to move to an adult placement or back to their communities towards a more independent living style.
	Service barriers & challenges	Age boundary, cultural change, bed availability, transition delays, destabilisation, uncertainty, disengagement from therapeutic relationships & education, specialised community placements, adult staff training, funding, safeguarding on ward	Transition delays accounted for destabilisation of mental health that further impacted transition destination in terms of security level. Transition barriers and challenges were the risk factors for positive transition outcomes pre-, during-and post-transition. National services are usually out of the person's catchment area and commissioning is a determinant factor.
	Geographical location	Catchment area	FCAMHS are national services and they admit young people from any part of the country. Therefore, when discharging young people to adult services they have to liaise with local authorities of the young person's catchment area and decide on their adult placement. However, specialised community services are not always available in the young person's catchment area and young people

			might end up moving far away from home.
	Discharge into community	Structure and routine, disengagement	Young people moving back to their communities or community supported accommodations needs to have a structured routine to avoid reoffending and mental illness relapse.
Transition facilitators	Legislation	Mental Health Act extended 117 leave	The MHA acted in most cases as a protective factor for young people, as it ensures aftercare. Young people moving to community placements can go and spend the night at the community accommodations under extended leave 117.
	Joint working	Receiving service CPA, meeting MDT	Joint working within and across services involved a collaborative approach adopted by services to facilitate the transition process.
	Visits to placement	Visits to placements	Visiting the hospital young people are moving to, may contribute to better transition outcomes. Having met with the adult key workers makes a difference to young people.
	Family involvement	Attending CPAs, visiting new placement, preparing for home return, containing anxieties	Successful transition outcomes included the family and receiving services.

8.3.2 Young people, family interviews and adult key workers

Table 20. Cases of young people interviewed within 5 months of their transition between January 2017 and December 2017

Case	Evidence of joint working	Diagnosis	Transition destination	Parent interviewed	AMHS clinician interviewed	FCAMHS clinician interviewed	Transition outcome
Joanne	No	Emerging BPD	community setting	No	Yes	Yes	poor
Miriam	Yes	Schizophrenia, PDs	MSU	No	Yes	Yes	poor
Ruth	Yes	ASD	MSU	Yes	Yes	Yes	poor
Kelly	No	Emerging BPD	MSU	Yes	N/A	Yes	No transition
Mike	No	ASD, psychotic episode	HSU	No	Yes	Yes	poor
Kenny	Yes	Asperger's syndrome, mild LD, bipolar affective disorder	Community forensic unit	No	No	Yes	good
William	No	Bipolar affective disorder, mild LD, ASD	MSU	Yes	No	Yes	poor
Noah	Yes	ASPD, mild LD	LSU	Yes	No	Yes	good
Elijah	Yes	Schizophrenia	MSU	No	Yes	Yes	ok

Ethan	No	Schizoaffective disorder, mild LD, ASD	MSU	No	Yes	Yes	No transition
Ben	No	ASD	MSU	No	Yes	Yes	poor
Liam	Yes	ASD	LSU	No	Yes	Yes	good
Henry	No	Bipolar affective disorder, mild LD	MSU	No	No	Yes	poor

8.3.2.1 Examples of good transition

Noah

I met with Noah's family in mid-January 2017 to carry out an interview about their child's prospective transition. The parents were worried about the forthcoming transition and about the impact of the process on their child. They highlighted that the patient would not respond well to environment changes and it would take a considerable amount of time to adjust. Their past experiences with other services had been frustrating and they even expressed that staff members had been bullying their child. Therefore, they had similar concerns about his transition to adult services, as his developmental age lagged behind his chronological one.

"My child has a learning disability and chronologically might be an adult but emotionally is like 12 years. This is my real worry going to an adult ward. He needs people to be there, he needs a lot of structure, a lot of support. I don't think he is ready to move to adult services." Parent 1 Mother

"When X goes to a new place makes the worst thing to happen to feel safe." Parent 2 Father

When I followed up Noah, I was taking notes throughout the interview with the patient, as I was not allowed to bring an encrypted recorder on the ward. We gathered all together in the visitor's room before the CPA meeting and had a chat with the patient and his parents again. He said that he liked his new placement and that his transition had gone well taking about a year from referral to discharge to adult services. He seemed content with this new placement, in which he had been approximately for 3.5 months.

"In child services everything they thought was warning sign" Noah

And he would be soon restricted. For example, they had as warning signs certain behavioural cues he would express before acting violently in FCAMHS.

Kenny

I visited Kenny in his community placement. The psychiatrist mentioned that his transition took up six months because there were concerns about the patient's suitability for the service regarding risk, as he had a significant forensic history and limited engagement in therapeutic progress. Therefore, he spent there a probational 4-week period to see how it worked and then he was moved to the new placement. She also said that the transition worked well and the patient's RC from FCAMHS organised everything and she had attended his discharge CPA meeting. His psychiatrist said that she thought it was a honeymoon transition and would not have expected that it would go that so well in terms of his adjustment. The patient mentioned that his experience is FCAMHS was not the best but not bad. He also said that they told him a few months before that he had to move to adult services.

"It was really good that he got to stay in his new placement for a 4 week period to see if I liked it or not and also got to know the staff and the people there and could get used to them." Adult Psychiatrist 1

He said he was happy being there because it was very close home and initially he could go home every month and at the moment every weekend. His parents were pleased because forensic child services were a long drive for them. He mentioned that he just started attending college courses .He said he was much happier there and feeling much better in terms of his mental health.

Liam

Liam's adult RC mentioned that the services coordinated well with FCAMHS and the young person had a smooth transition. His RC said that the patient's mental health had significantly improved, and the young male looked more hopeful towards the future aspiring to attend college. Liam was happy with his new placement and recounted that FCAMHS managed well his transition.

"It was fine. I was going to go to MSU but my clinician said to the commissioners, let's not move him for the sake of him turning 18, let's actually sit down together and decide. He did a good thing. He'd written a letter to them and they agreed to come down and have a meeting. Luckily, they decided to step down. So I'm grateful for that. What I'm really happy for is having a home leave in this short amount of time. It 's really fantastic…Going back to college and getting all my life; life wasn't great before. But finally I'm in the right place and I've got a plan." Liam

8.3.2.2 Examples of poor transition

Safeguarding in adult wards

William

I followed-up William and booked a meeting with the ward manager. William did not seem to do much better in terms of engaging and communicating his feelings. During the time, I was supposed to meet with him, he was in a psychology session and I told him we would meet a bit later. However, after the session he went to the quiet room because during the session he reported he wanted to self-harm-by banging his head on the wall. Therefore, I agreed with the ward manager to visit him again another day the following month. When I asked William whether he was experiencing any problems on the ward, he responded:

"There is one guy bullying me. I am worried this will affect my progress…I have told staff and they said they will help me file a formal complaint. I have told my parents. My parents are trying their best with this." William

I met with William's mother ahead of his transition. At the time, she did not know where her child was going, and she was worried based on her previous experiences with services. Her son had been in contact with

CAMHS from an early age and he had also been admitted to an adult hospital due to shortage of beds in child and adolescent inpatient services.

"They haven't told me where he is moving and because he has ASD and a learning diusability and a mental disorder, he is very vulnerable. I don't think he's ready to be surrounded by adults." Parent 3

Preparation for transition

Mike echoed his frustrations due to the service barriers that he encountered whilst waiting to be moved from FCAMHS. He expressed resentment about not being prepared for the upcoming transition and the lack of proper transition planning, as he did not visit the placement before.

"They don't prepare you at FCAMHS, they just tell you where you are moving." Mike

When I asked him about his experience in FCAMHS, he replied: "Boring." He said he liked the staff more in the adult hospital because in child services it was difficult to find them on the ward when he needed them. He said he felt better that he had moved to adult services. He mentioned that it was OK that there were older patients around him and he got along with them. However, he was quite isolated and disengaged in his room, according to the staff. The patient said he had not visited the adult hospital in advance or any of the staff-only his RC had visited him once whilst he was in FCAMHS. He mentioned that his parents are helping him and they would like him to be closer home and he seemed to understand this was not possible. He understood he had to move because he had turned 18 years but still thought child services did not prepare him adequately for the transition. As I interviewed his psychologist, social worker and clinician in adult services and also attended a ward-round meeting and discussions about the young person including his nurses and the whole MDT, the team expressed concerns about him being isolated and spending most of the day in his room. They were concerned about him being bullied by older peers on the ward.

Information about date and time of transition

Transitional delay

Kelly was so frustrated and expressed that she did not care whether she was in hospital or not. The engagement in the interview was minimal and the only theme that was repeated was her resentment on being detained in secure services.

"I don't know when I am moving. I'm not sure…I don't feel anything. I don't want to be in hospital, so I don't care." Kelly

Her mother was worried about her upcoming transition and she clearly stated that Kelly could not move to adult services.

"She dresses and thinks like a 12 year old. Her developmental age is not 18. I'm really worried." Parent 4

Ethan did not know when they were moving to adult services and they repeated what their RC had told them that the transition was subject to delay.

"They had not given me the date of transition to adult services probably due to shortage of beds."

There was not a definite date for Ethan's transition. I visited Ethan in FCAMHS whilst he was waiting to be transferred to a new placement. The uncertainty of the transition date and lack of familiarity with the adult placement seemed to have a huge impact on his well-being, which his support worker also mentioned. The patient said:

"It is a very frustrating experience of waiting and not knowing." Ethan

He said he had not met with his future RC/doctor but he would like to. The patient said that he was stressed about his transition because he did not know how the place looked like and how staff would be there.

"It's scary; I'm scared."

Lack of structure in the community

Joanne moved to a community-supported accommodation near her home area. Her support worker mentioned that she had relapsed and was engaging in self-harming behaviour:

"I think the problem is that this change is overwhelming moving from a restricted environment to an independent one. It is quite a change moving from child services to community services. She needs more support and it might be better for her if she had more resources available." Healthcare Support Worker

Lack of a structured routine seemed to account for Joanne's withdrawal and depressive mood. Joanne described her transition as follows:

"The transition was quick. I moved here three months ago and there was a referral meeting." Joanne

Adjustment in adult placement

Henry was very upset during the interview and said multiple times that he did not wish to engage in any group psychology sessions. He also stressed that he did not get along with his peers on the ward because they were much older than him. He had a very negative attitude towards the adult service and seemed not to have not built a relationship based on trust and rapport with his new RC. However, he had been in FCAMHS for two years and at the new hospital for only two months. The nurse mentioned that his mood fluctuated and depending on the day and also said that he had presented with sexualised behaviour towards other patients and staff members. Yet the patient mentioned that he did not understand why he

would not be given a leave since he had not been in seclusion or caused any troubles.

"It's like being in prison; I can't do anything here-it's like they hold on to me…it is too loud here and I want a quieter place and I want to move on with my life." Henry

Miriam was in acute phase of her mental illness when I first visited her in FCAMHS and again in AMHS. She was a high-risk patient who could not adapt to adult services due to her multiple personality disorders and psychotic symptoms. Her RC was extremely worried when I visited her in forensic medium secure services and was trying to move her to a high secure service. However, they did not have an available bed and the RC pointed out that they could not manage her risk on the current ward. The patient was not aware of her transition and was in such an acute phase of psychosis that she was disconnected to external stimuli. When I asked Miriam about her transition experience, she responded, as follows:

"I don't know where I want to be." Miriam

Multiple transitions

I met with Ruth's father after my initial visit to FCAMHS and interviewed him about his child prospective transition. He seemed quite confused about Ruth's transition to adult services.

"I don't understand where she is going. I am really worried. She asked to go to a low secure service and I am trying to liaise with social services why they have not contacted me. I feel this is totally disgusting." Parent 5

The first transition to a community placement did not work out and she returned to FCAMHS and her RC had to identify a new placement that was a low secure unit. However, at the time of my visit she had transitioned to a medium secure unit in the same hospital. Ruth said:

'I don't like the current service much because they are too strict.' Ruth

The adult RC mentioned that the young person was doing well and they thought there would be a decrease in terms of security level at some point. Yet, she said that community seemed to have been a big jump and, that the young person could not meet the expectations, and this explained why the community plan failed. The RC also reported that Ruth was not interested in making friends and/or relationships on the ward.

Prison transfer

Elijah was moved to a medium secure hospital but had not finished his sentence. The young male was aware that he would go back to prison once his treatment was over and based on his past custodial experience of being subject to bullying, he was worried about returning to prison.

'I will get worse, if I go back to prison.' Elijah

Elijah described his transition experience from FCAMHS to AMHS as being positive and feeling safe in hospital. The patient mentioned that his last RC had helped him when he was having a difficult time waiting to be transferred as had multiple meetings discussing about his behaviour.

Ben

The patient was diagnosed with mild learning disability and autistic spectrum disorder. During his stay in forensic child services the patient had reported hearing voices but then they stopped and since he has not been presenting any psychotic symptoms. His adult clinician described the young man as a very challenging patient and high risk according to FCAMHS. He had been in seclusion frequently for extended periods but the adult clinician thought that he should not spend so much time isolated, as his behaviour would escalate. He explained that in specialist adult service, they do not reinforce seclusion for more than two days. Clearly, the clinician believed that FCAMHS had been overprotective towards young people such as the patient and, therefore they cannot reflect on their disturbed behaviour. He considered extended seclusion as a bad practice-

response to disturbed behaviour. The patient had caused lots of problems in child services and the staff did not seem able to manage him. Yet, while in adult services during the past six months, the patient seemed easier to manage. When I asked the patient about his experiences in FCAMHS, he answered: “Crap.” He said that he did not get along with his peers because he was always picked on. He characteristically said that once he stayed in seclusion for six months because he reacted to someone who hit him. During these six months he was not allowed to have any contact with his parents. There was lots of confusion surrounding this patient’s transition due to commissioning issues. Transition delay occurred since an appropriate place could not be identified. He was initially told that he would move somewhere near his home area. However, two weeks before his transition he was informed that he was going to a different hospital in a different geographical location due to a lack of bed availability.

“I was told two weeks before. I didn’t know where I was going. They came and told me. My parents didn’t know…I was wondering, I wanted to know where I was going.” Ben

There was no collaboration between FCAMHS and FAMHS before, during and after the patient’s transition with uncertainty regarding transition destination and timing. The clinician also stressed that there should be better coordination and liaison with the community services close to the patient’s home and he deemed this was highly problematic as there was no community team involvement in the transition process.

The above cases exemplify certain barriers and facilitators in the transition process. In the last case, the young person moved to forensic adult inpatient services had a particularly mixed and ambivalent transition experience. Poor liaison between child and adult services alongside poor handover planning was a major theme. FCAMHS need to pass on information to the receiving service and to the local community team. The primary aim is to move young people to community settings and supported accommodation and usually forensic inpatient services are treated as

transitional accommodation. However, in this case the adult receiving service did not attend in person a CPA to meet with the child-service team and the young person did not visit the adult placement ahead of his transition due to its abrupt character. Another risk factor was the distant geographical location of the adult placement whereas the young man felt isolated from his home area. The long travel distance impacted family involvement and they could not afford to visit their son on a weekly basis. I tried to contact the parents of this young person, as he had agreed to interview them but I did not receive any response back. His RC in FCAMHS and FAMHS were both interviewed and provided different views on the patient. The FCAMHS clinician described him as a very challenging and risky young man whilst the adult RC thought that they could manage him in adult services. The young person's adverse FCAMHS experience being in seclusion for such a long time added to his negative and uncertain experience during transition. The young person expressed that he did not have any control over decision-making regarding the geographical location.

8.4 Discussion

The findings reflect young people's needs and experiences throughout transition periods based on their own reflections and understanding of care. Families voiced similar views to young people and pointed out the uncertainty of institutional change brings alongside the impact on their children. Healthcare professionals' views reflected on the barriers they encounter when transitioning young people to adult services. The differences between child and adult service cultures were evident in the interviews (Singh *et al.,* 2010). FCAMHS professionals had a much better understanding of the developmental needs of young people and adult workers in both community and forensic inpatient services were more likely to quote independent living as the primary goal.

This study extends the descriptive data from the previous studies and adopts an interactionist approach to understand, reflect and give meaning this group's experiences. Young people described transitions as violent

and abrupt incidents instead of an ongoing well-informed process that has a beginning, middle and end. Violence was re-enacted through lack of readiness and abrupt transitions in often-unsafe adult placements where young people were placed with much older peers. All the young people mentioned that they were the youngest on the ward or community setting. One young person reported that they experienced bullying by older patients they had been in forensic services long-term. Consequently, safeguarding of young people is jeopardised when they move to adult placement where little supervision takes place. Adult healthcare professionals pointed out to the difference in staffing between child and adult mental health services.

The interviews with the FCAMHS healthcare professionals elicited three main themes: transition process, barriers to transition and facilitators to transitions. The majority of the healthcare professionals described a standardised procedure followed by all national services to discharge young people reaching 18 years. Yet, they did not mention using a shared protocol that guides the transition procedures. All FCAMHS professionals mentioned CPA and Mental Health Act as the points of reference for transitions. The Mental Health Act was structured the transitional pathway considering that all young people were sectioned, and the legislative framework required aftercare for all young people. However, transition destination determined the process, depending on the type of service young people were transferring to.

Forensic adult inpatient services presented a major challenge to smooth transitions. Lack of bed availability in high, medium and low secure units was a recurrent theme liable for transition delays affecting negatively young people’s mental health and being accountable for young people’s mental health deterioration. Adult healthcare professionals in forensic inpatient services emphasised that prisoners were given priority and would often be admitted before the young people transferring from FCAMHS. This resulted in long periods of waiting in child and adolescent services and increasing stress and uncertainty for young people and their families.

Repeated trauma and loss through service transitions builds on anger that might result in violent incidents. Majority of these young people would meet the criteria for developmental trauma with early years marked by unsteady relationships with parents, abuse (sexual, physical), neglect and parental mental health problems (Van der Kolk, 2017). Their family environments have been unpredictable and the way transitions are currently managed, these traumatic experiences are re-endorsed through services. Hence, transitions from FCAMHS to adult and community services should adopt a developmentally informed care model that constantly addresses young people's and their families' needs and concerns. Moving to an adult placement that is less trauma-attachment oriented in their care approach is a major barrier for young people's mental health improvement. Escalation of violence was quite salient in this study when visiting the adolescent medium secure units, as often the young people knew that they would be transitioning to adult services but they were not informed about placement, time or would not meet the MDT at the receiving service. Those young people who did not participate in the study were mostly in seclusion or quite angry and frustrated as they were awaiting the transition date and new placement information. Majority of the cases were so complex in terms of multiagency involvement and different views of the young person' needs that would result in 12-month delays. During waiting time for adult transfer, young people disengaged from therapy and education-as they had turned 18 years- and were just sitting in their rooms.

Singh et al., (2005) described adult services as being built on: ''successive influences of neurology, phenomenology, psychology and sociology'' (p. 292), and over time developed community treatment strategies that were once ''entirely asylum-based' (Mulvale *et al.,* 2013). Clinicians from FCAMHS shared very different views from those in adult services and, particularly those in forensic adult services. All RCs in adult services reported that they were trying to enhance the young people's independence from service and, therefore they could structure their days

as they wished. However, this might have derived from the fact that adult services do not have sufficient funding to provide the range of activities offered by FCAMHS, as one adult clinician stressed. Young people newly transferred to adult services reported that they had seen their responsible clinician once or twice since the day they moved. Whilst in child services, they would have much more frequent input and contact with their responsible clinician than in adult services and this loss of consistency and therapeutic hold seemed to be anxiety provoking.

Abrupt change from family involvement in the care planning towards a completely independent approach is usually not understood by young people. However, in FCAMHS young people often do not have a close family member involved in their care and they might be disconnected from their families given their dysfunctionality. Yet, one young person who participated in this study and moved to an adult low secure unit for people with learning disabilities had his parents involved in their care. Both parents were quite involved throughout their child's transitional journey and they attended the CPAs at the receiving service, as the RC was keen to facilitate this process.

8.5 Conclusions

The qualitative interviews extended current understanding on young people's transition experiences and outcomes. Including interviews with healthcare professionals from both child and adult services enhanced understandings on policy, processes and practice during periods of transition. Healthcare professionals from child and adolescent services sometimes held different views from those of the adult healthcare providers because they encountered different challenges throughout the transition process. FCAMHS healthcare professionals had to identify a suitable placement for young period based on risk and mental health assessments whereas commissioners had a say and they had to liaise with numerous stakeholders, including commissioners to facilitate the upcoming transition

alongside mitigating anxieties for in young people and families and carers. Transition delays due to problematic coordination between services and shortage of beds in adult services and reluctance of community placements to take on young people with forensic histories were the common challenges they had to overcome and deal with. FCAMHS healthcare professionals were accountable for the young peoples' trajectories and had to make important decisions concerning risk assessments. Adult mental health professionals had to reflect on the young person's case and facilitate the transition from child-oriented services to adult-centred environments characterised by a more independent model of care. They had to understand the young people's needs based on limited knowledge as these young people were newly admitted patients and provide adequate care that would meet their needs sufficiently. Parents and carers were anxious about their children's upcoming transitions and often were not provided with adequate information for the new placements and they did not have the opportunity to visit these services to meet with the members of staff who would be looking after their children. Lacking the legal and medical knowledge they were often confused about what processes have to take place before transitions and they felt that services did not provide them with adequate resources to alleviate their anxieties. Young people did not understand the dynamic character of the transition process and they mostly emphasised to the infrastructural and procedural difficulties they came across such as transition delays and uncertainty surrounding their transition date. The final chapter summarises critically the findings of the four different phases of this study and provides a critical discussion including key themes and contributions of the current study to the empirical and conceptual literature of transitions.

9 Discussion and Conclusions

9.1 Literature gap, research questions and main findings

This research study has focussed on transitions of care from all nationally commissioned adolescent medium secure units in England. Young people admitted to forensic inpatient services compose a very particular group with complex needs and high-risk behaviour. This group presents with comorbid mental health problems and neurodevelopmental needs and has been detained under the Mental Health Act. Looking at their needs in times of transition to adult services was achieved by focussing on services' infrastructure and processes and by interviewing healthcare professionals, families and young people. Clinicians, families and young people expressed frustrations about the way transitions are currently organised and their voices echoed previous research findings on transitions from routine CAMHS to adult services (Singh *et al.,* 2010). Yet the transition literature remains limited and there is no up to date knowledge on the barriers and facilitators for transitions from forensic child adolescent services. The existing gaps in the literature underscored the rationale of this PhD thesis to shed light on transitions from forensic adolescent inpatient services to adult and community services once young people reached the transition age boundary. The findings from this research study aimed to understand and reflect on service users' experiences and also to identify the transitional barriers to successful transitions in order to improve current policy and practice.

Key findings relating to the research questions from the four interlinked phases of this research study are summarised below:

9.1.1 Phase 1: What have been the demographic characteristics and prevalence of mental health disorders in young offenders in detention?

Chapter Five, the systematic review meta-analysis findings were in line with current research showing that young people in secure settings present with much higher prevalence of mental disorders and mental health symptoms than young people in the community (Fazel *et al.,* 2008).

Emerging personality disorders (PDs) were highly prevalent in both sexes. As research suggests, PDs are predictors of reoffending and need to be adequately treated in younger populations. Investing in empirically supported intervention strategies has the potential to interrupt the criminal trajectory associated with emerging personality disorders (Vizard, 2008).

Learning disabilities (LDs) were also common in young offenders, and the research literature suggests a link between learning disabilities and reoffending (Talbot and Riley, 2007). Studies have been using IQ-cut off scores to detect learning disabilities (O'Brien, 2001). Offenders with learning disabilities may lack understanding of their detention and can become victims of bullying (Talbot and Riley, 2007). Exacerbating these problems, specialist services, such as mental health-in reach, are often not available. Consequently, offenders with LDs may be at high risk of reoffending and developing further behavioural problems. Therefore, it is necessary to invest more in education for young individuals whilst in prison and more importantly when they return to the community (Cortiella and Horowitz, 2014).

Young female offenders presented with an atypical pattern of psychopathology (in comparison to community populations) that needs further investigation, such as high CD and ASPD rates. Future research should focus on disorders that are traditionally more common in males including CD, ADHD and ASPD. Mental health services for detained young

people presenting with emerging personality disorder symptoms should design effective care pathways (Hill *et al.* 2014) addressing past trauma and insecure attachment styles to interrupt the psychopathology and reduce the risk of reoffending.

Attempted suicide was highly prevalent in this study composing a major concern for young offenders in custody. Prior research has reported that suicide attempts elevate once young people are admitted to custodial settings (Moore *et al.,* 2015). Sadly, lack of prediction accuracy increases the risk for attempted suicide whilst in prison. More regular screening for young people presenting with risk factors should take place to reduce the prospects for suicide attempts (Bhatta *et al.,* 2014). PTSD and negative life events should be taken seriously into consideration when screening young offenders (Bhatta *et al.,* 2014). The current findings are corroborative of the literature with females engaging more in self-harming and suicide behaviour (Tekin *et al.,* 2016) than males. Some cohorts of young female offenders are in heightened risk for expressing severe psychopathology especially when first admitted to a secure setting and high-risk groups should be identified before their symptoms worsen. Early screening and diversion from the youth justice system should be enacted for moderate and high-risk populations to treat their symptoms more effectively. Systematic research suggests that treatment and diversion programs contribute to crime de-escalation (Cuellar *et al.,* 2006).

The presence of high ADHD rates among young offenders in prison settings raises major concerns. Lack of care-pathways and poor management for incarcerated young people with ADHD remains problematic whilst paucity in long-term outcomes eliminates efficient treatment interventions. Young et al. (2011) have highlighted that ADHD symptoms can be treated resulting in less violence in this group, if screening improves and treatment strategies are implemented. Some key recommendations to improve policy and practice are properly trained staff

in prison settings, collaborative work among services and more funding resources available (Young *et al.,* 2011).

This review underscores that young offenders with mental health problems comprise undoubtedly an extremely vulnerable group. Therefore, this cohort often needs to be transferred from prison settings to secure hospitals and other mental health services where they can receive proper care. Much attention needs to be paid to screening and detecting high-risk groups entering custody in order to plan and execute transitions to appropriate services. Yet, lack of bed availability limit suitable care-management.

Temporal relationships regarding mental health problems and the impact of incarceration should be considered. As the current review revealed, youth entering the prison system present with more anxiety. Recent research (James, 2013) pinpoints that detention exacerbates current mental health problems and impedes rehabilitation back to the community due to inadequate educational support and proper treatment. Therefore, multisystemic-person-centred community programmes seem to be more effective incorporating family, school and peer group and contribute to less offending (Lambie and Radell, 2013). There is a need for more longitudinal studies that implement community-based programmes as alternatives to incarceration to promote restorative justice as an effective alternative for young offenders.

9.1.2 Phase 2: What are the transition policies, processes and practices of FCAMHS for young offenders in secure adolescent units in England?

Chapter Six, the mapping exercise provides a framework to describe young people close to transition age accommodated at inpatient medium secure units across England. The key finding from this study was that transition timelines depended highly on bed availability in adult mental health services. Accordingly, shortage of beds disrupted significantly planned and

organised transitions. However, bed availability depended upon adult services' infrastructural problems and was unrelated to the care of patients needing transition.

Majority of these young people had to wait for six months to be moved to adult services. Presumably, reaching a joint decision among services and commissioning parties hinders timely transitions. Those young people waiting to transition to adult forensic hospitals experienced longer waiting than those referred to community services. However, transitional delays account for deteriorating mental health and poor transition outcomes that often may affect young people's future care-pathways.

9.1.3 Phase 3: What are the annual transition rates and pathways from FCAMHS?

Chapter seven, the retrospective case note review allowed for more holistic overview of a national sample. Yet, there were many similarities between those young people in the mapping exercise and those included for the case notes. This study was retrospectively designed and based on archival records of young people. Looking the case records of young people offers a good understanding on the complex nature of their needs including family and forensic backgrounds, comorbidity of mental disorders, learning disabilities and suicidality but the interpretation of the results remains limited.

The findings of this study highlight the need for more flexible age criteria underlying the transition process. This group of young people presented with complex and multiple needs and all of them had comorbid problems. Therefore, rigid age criteria impose an *one-size-fits-all* model that does not respond to each young person's needs. Many of the young people had particular complex developmental difficulties that should be taken into consideration before placing them to adult settings. A great number of this group had learning difficulties and neurodevelopmental problems but still had to transition to adult services based on their chronological age.

Transition readiness is a key issue when planning and managing transitions for this cohort (Livanou *et al.,* 2017).

Only a few pathways were generated from the case note reviews pointing out the distinct care-pathways that this cohort experiences. Although this group of young people shares several clinical, forensic, and family characteristics, their pathway and trajectories differ. Majority was transferred to community placements. However, due to lack of follow-up with these young people by referred services or longitudinal studies, we do not know whether their mental health problems improved or community care was supportive or whether they presented with violent behaviour.

Whilst over than 70% of the sample had a neurodevelopmental disorder and/or a learning disability, only 25% went to specialised services. Notably, one patient had ASD and returned to prison because a receiving specialist service could not be identified. Previous research has shown that adult mental health services lack of trained staff for neurodevelopmental disorders and ASD and this population often falls in the gap of the system (Swift *et al.,* 2013). For instance, prison environment is not appropriate for young people with learning disabilities and autism and their needs are not adequately met. This group of young people is more likely to become subject of bullying in prison increasing the risk for mental health deterioration. One patient from the case note reviews did not wish to return to prison and had asked to be transferred to a hospital. Yet, he had no ultimate say in decision-making and his wish was disregarded. According to his records, he had been a victim of bullying in prison before being transferred to FCAMHS and this explains his fear of returning. This patient had attempted suicide when he was in YOI and this incident triggered negative attitudes towards prison. It is not known from his records whether his fears were addressed during and upon discharge. Adult prison could be either more stressful for this patient but given his lengthy sentence historical risk factors seem to be overlooked. It should be noted that according to the National Audit Office (2017) suicide attempts in UK adult

prisons stroke the highest number on record along with self-inflicted deaths (Chabalala, 2017). This report highlighted that 40% of prisons did not provide their staff with mental heath awareness training and mental health care is provided only for 10% of prisoners. As these cases illustrate the complexity of each young person's developmental and environmental trajectory is manifested in their violent behaviour and mental health symptoms.

These young people present with personal, environmental and family risk factors that have contributed to their offending. Individual factors such as age compose a significant risk factor. Adolescence is critical period where multiple changes occur and could result in risk-taking behaviour (Duran-Bonavila *et al.,* 2017). Presumably, violent behaviour might not persist later in adulthood and could be associated with the transitional period of adolescence (Valois *et al.,* 2002).

9.1.4 Phase 4: What are the views and experiences of young offenders, their carers and health providers concerning the transition process?

Chapter Eight, the qualitative interviews revealed important information about young people's experiences. Each FCAMH service mentioned the same procedures regarding transition preparation. However, each service seemed to adopt a different approach when preparing young people for transition. The transition outcomes reflected good or poor liaison between staff members within the FCAMHS teams and with AMHS and community adult teams. Females in this study composed a particular group that should have a distinct care and transitional pathway depending on their mental health and risk presentation. I followed up four young females out of the 10 eligible for this study and all of them presented with emerging personality disorders and comorbid mental health problems. Adult key workers responsible for their care described their adjustment in adult placements as being poor.

The interviews facilitated triangulation of the findings and adoption of a reflective approach towards the young person. The difference between FCAMHS professionals' perspectives and adult key workers was apparent in their responses. There is an imperative need to hear the personal views and experiences from the young people discharged from inpatient FCAMHS to gain an in-depth understanding of their needs, complexities, difficulties during transition and their recommendations on improving transition service delivery. These findings highlight the complexities of this group of young people and demonstrate their multiple transitions throughout services. However, being detained under the Mental Health Act and being confined in controlled secure environments such youth custody and forensic inpatient services, young people are rarely be given a voice to express their personal views and experiences about the placements they have moved. Following up young people throughout their journey across services increased our understanding and helped young people to reflect and gain insight on their experiences. Understanding transitions and needs through the lenses of young people and the system around them such as carers and health care professionals, allowed for more holistic interpretations.

9.2 Original contribution to knowledge

This PhD thesis fits in with the Department's of Health five-year initiative plan to design and improve transitions for young people in medium and low secure services. In order to plan better transition services for young people, there is a need to reflect on this group's experiences first and also gaining an understanding on the experiences and perspectives of all stakeholders involved in the transition process (Broad *et al.,* 2017). Interviewing the whole system around the young person has been an important contribution to the literature as long as to improving clinical practice and existing policy guidelines. The findings of this thesis will inform clinical and policy decision-making based on young people's experiences and also on

services' guidelines and transition preparation and infrastructural procedures. Including a wide range of healthcare professionals from both forensic child and adult inpatient services has helped to understand in-depth the barriers and facilitators to transitions from different perspectives. The split between child and adult services has been clearly highlighted throughout the interviews and, therefore, emphasising the need for more joint services. Simultaneously, joint services comprise a major barrier in clinical practice, considering that different institutions and different disciplines within the same team have separate missions and goals. Therefore, joint services need to be integrated services with same approaches and goals to improve transition preparation, management and outcomes.

9.2.1 Empirical contributions

This thesis added empirical and conceptual contributions to the current literature. The empirical contributions pertained to the meta-themes that were generated from four interlinked phases. This study reflected on the impact of transitional delays on young people, their carers and child and adult healthcare professionals. Therapeutic endings with parallel care were emphasised by healthcare professionals as facilitating transitions and this study extended understandings on their views and experiences. However, in practice, parallel care did not take place in most cases due to several infrastructural weaknesses pertaining to coordination amongst different services. Another important empirical contribution of this thesis concerned the most vulnerable group of young people within this subgroup of adolescents in FCAMHS and moving to adult services, which is comprised by young people with learning disabilities and neurodevelopmental problems. Lack of appropriate care, especially, in adult services was the greatest challenge for all stakeholders involved in the transition process. Then, lack of readiness was a recurrent theme throughout this thesis, reflecting on healthcare professionals', young peoples' and families' views and understandings of the young peoples' needs. Organisational issues

were found to be extremely disruptive in the transition process such as availability of beds, lack of attendance in discharge CPA meetings, and poor handover planning and management alongside missing medical and psychiatric records of patients. Female young offenders presented with different needs at different stages of their transitions and all of them had emerging borderline personality disorder including severe self-harming symptomatology. Clinical care-pathways need to be distinct for this group of patients and tailored to their presenting needs. Geographical location was an ongoing issue throughout the interviews that acted as a barrier to smooth transitions. A few young people were placed in geographically distant locations far from their home area. This extended to limited parental visits in adult services. Parental involvement comprises a significant protective factor in the resocialisation process for the young person. However, in such cases, where the parent is not adequately involved, the resocialisation process may be delayed, disrupted and/or impeded. The young person is undergoing a transition at both institutional and developmental levels, and parental involvement can be critical to this life change for the young person. Young people may need support from consistent key figures in their lives such as parents and healthcare professionals from FCAMHS. This research extended understanding on transition policies, practices, outcomes and organisational procedures including different stakeholders.

9.2.2 Conceptual contributions

This research study extended current knowledge on transition processes from referral time to discharge process and transition outcomes and destinations for those young people leaving forensic inpatient child and adolescent mental health services. The conceptual contributions built on the findings and the existing literature on transitions from routine CAMHS and crime and psychopathology in young offenders in detention. The conceptual contribution pertained to adding and linking current findings from this research study to the conceptual theory in young offenders. The existing literature has extensively examined the association between crime

and psychopathology alongside risk factors that contribute to offending. The findings from this research study show and corroborate the relationship between mental health comorbidities and crime among young people. The mapping exercise and the case note review revealed that all young people had very complex comorbid needs and some of them had experienced trauma in the past and had a forensic history. Another conceptual contribution of this research study pertained to the role of parents in the transition process. The extant literature has emphasised that parents can been seen as a protective factor in young peoples' lives and to the transition process specifically. The findings from the qualitative interviews revealed that those young people who experienced smooth transitions were more likely to have a parent involved in their care. However, in some cases, the involvement of the parent was not sufficient to compensate for infrastructural weaknesses impacting the young person's wellbeing at the new placement. The results of this research study pointed out the inherent difficulty in risk assessment and discharge and resocialisation into community settings. The existing literature has shown that risk assessment and offenders' discharge back to the community is a multifactorial process with further implications on the victims, community and society as a whole. In this research study, presenting risk amongst young people before transition to adult placements determined their transition pathway. Release back to the community need to take place after careful consideration and comprises a highly complex task for the stakeholders involved, as it was apparent in this study.

9.3 Key meta-themes based on conceptual and empirical contributions

There is a lack of literature on young people in transitions from inpatient FCAMHS and this might derive from the difficulties embedded in conducting research with this group of young people. Engaging young people with such complex needs in research is quite challenging given their vulnerabilities. Following up young people discharged from nationally

commissioned forensic inpatient services was another challenge, as majority was discharged back to their catchment area. Transition research should be longitudinal and cost-ineffective.

There are multiple factors that can lead to poor transition outcomes. Those young people with comorbid mental health problems and poor family and/or social support tend to present with the worst outcomes. The findings showed differences between males and females. For instance, females with emerging borderline personality disorder regardless of their transition placement were more likely to carry on self-harming and aggressive behaviour. Those males with learning disabilities and ASD along with schizoaffective disorder or presence of psychotic illness were more likely to be less engaged in adult services and feel distrust towards healthcare professionals. Only two young people had established trusting relationships with healthcare professionals from adult mental health services.

9.3.1 Difference is services' cultures

Adult services reinforce an isolated model for the young person. The shift in age status has an impact on their well-being. Young people are more likely to experience difficulty in building secure relationships with adult healthcare professionals. This occurs due to lower staffing and, especially lack of trained staff for young people who need specialised services. Moving to an adult service is a difference in culture for the young person's family as well as the family is trying to adjust to the new service's infrastructural procedures. Those young people with autism and learning disabilities seemed the most disadvantaged ones, as they were experiencing isolation on adult wards. The five parents included in this study had all experienced multiple transitions across services being involved in their children's complex care-pathways from being in psychiatric hospitals to adult hospitals to FCAMHS and then to adult services. Parents described as having a positive relationship with the responsible clinician from child services whilst this would not be the case once the young person moved to adult services. The adult responsible clinicians interviewed for

the purposes of this study did not report on building trusting relationships with parents or involving them directly in the young people's care.

Multi-agency/service collaboration becomes challenging heightened by the gap between child and adolescent mental services and adult mental health services (Davis, 2003). Child and adolescent mental health services adopt different care-planning approaches than those used by adult mental health services. Hence, transitions for young people become even more complicated and they might not be prepared for the more independent care-model followed by adult services. This evident gap between services contributes to poor transitions and mental health outcomes and, also increases the risk for reoffending. Those young people transitioning back to their communities have the poorest outcomes if they do not receive adequate care (Wright and Liddle, 2014). We know that about 68% of children who return to community will reoffend within one year (Beyond Youth Custody, 2012). Chitsabesan and colleagues (2006) found that young offenders released from custody encountered major challenges and their mental health symptoms worsened in the community. Service provision declines once young people enter adulthood, 18- to 20 years and often lose the support they were eligible for as children (Davis, 2003). Therefore, community discharge could be an ongoing process using effectively extension 17 leave of the Mental Health Act. Both FCAMHS and adult healthcare professionals could facilitate the process by providing ongoing support to the young people and their families.

9.3.2 Ending therapeutic relationships

Young people might encounter a greater difficulty in letting go considering that their childhoods are underlined by loss and/or trauma (Broad *et al.,* 2017).

Those young people approached to take part in the study who did not agree to be followed up once they transitioned to adult services, were not keen on leaving child services. During our interactions and through

observing their communications with their responsible clinician and other staff members, it looked as if they had established secure bonding with key workers from FCAMHS. As Lindgren et al. (2014) pointed out, young people feel ambivalent towards their prospective transitions due to the uncertainty of moving to a new service where they have to start all over again in building relationships with staff. Young people discharged from forensic services are less likely to establish trusting relationships with authorities, as they have received inconsistent care from parents and services in the past (YJB, 2016).

9.3.3 Complexity of needs and risk presentation

Many healthcare professionals referred to those young people transitioning from FCAMHS to community placements as being a highly unwanted group considering the stigma and severity of the index offence. These young people present with very challenging behaviours that cannot be managed in community placements due to lack of appropriate training and possibly anxiety to manage high-risk young people with comorbid mental health problems. Further, the stigma of the offence remains high and, therefore, community services based on the crime severity committed in the past will not accept those young people not presenting with risky behaviour upon discharge from FCAMHS. However, risk is a concerning factor along with past forensic history. Many of these young people have criminal records with severe offences ranging from five to 45. Considering the victims' and public's perspectives and feelings towards severe criminality, clinicians and policy decision-makers need to be cautious. There are cases where the young person cannot return to their communities as there is a need to protect both the victims and the young offenders. In other cases, young people might move to a community placement and spend a certain amount of time such as a month and then return back to FCAMHS because they could not manage independent living. Accordingly, both community services and the service users feel incapable of moving on. Adult services are less likely to adopt trauma-informed care and gain a developmental

understanding on young people's adverse experiences, therefore they tend to exclude and/or reject them (Wright and Liddle, 2016).

These incidents bring even more confusion to the young people and the clinicians who have to identify a new placement for the young person. It could be an extremely frustrating experience for the service user, as by first moving to the community, they were told by their child responsible clinician that they were ready to move on. However, they are 'returned' to the forensic services due to their incompetency of being independent in 'one night.' This transition has a regressive character that may have a tremendous impact on their mental health and their future risk presentation. This process could be seen as a 'double punishment' to the services' high expectations (Wright and Liddle, 2014). These young people experience repetitive rejection by key figures and services.

9.3.4 Young people in adult placements

Many young people and their families reported that they had been in adult psychiatric hospitals before moving to FCAMHS due to shortage of beds in appropriate services. This experience was described as being terrifying and shocking for the young person. The existing literature along with NICE guidelines underscores that young people should not be placed to adult mental health hospitals when they are below 18 years. The risk of placing adolescents in adult placements pertains to young people being vulnerable and prone to bullying by much older peers, and also their needs can be overlooked. Even young people who are legally adults encounter a number of difficulties when placed on adult wards and/or placements. It needs to be emphasised that these young people are leaving from FCAMHS units where they are the oldest amongst their peers and are transferring to new institutions, where they are the youngest amongst much older peers in their late 50s and 60s. This shift in social status and hierarchy in the institution they are placed can become very complex for the young person. Concurrently, they have to adjust to a new environment and also accept a new assigned status that is inferior to the one they had previously in the

institution they felt safer. Transition to adult placements then can turn into a terrifying experience where they lose relationships with key figures, peers, and their social and personal identity is shaken.

9.3.5 ASD and LD pathways

Many young people presented with learning disabilities and autism spectrum disorders along with other comorbid mental health problems. The lack of available community placements in their catchment area was often a major barrier to their transition. These young people would move to forensic inpatient services because another appropriate placement could not be identified near their home area. One young person with these needs was moved to an adult medium secure hospital not specialising in autism and the young person's presentation seemed quite poor in comparison to their presentation while in FCAMHS. Lack of appropriate care-pathways for these vulnerable groups has further implications on their rehabilitation and recovery and could severely delay and disrupt their reintegration to the community. Many of these young people present with neurodevelopmental needs and not a comorbid mental disorder that is perplexing to their transition to adult services. Having a mental disorder along with neurodevelopmental difficulties ensures their admission to adult units. However, it is not clear what pathways are more appropriate and what pathways are available for this group of young people. Adult healthcare professionals reported in the interviews that many of the young people referred to forensic adult hospitals did not meet the criteria for a mental disorder and presented only with autism and learning disabilities and when they were referred to them their discharge summary reported that they had. a mental disorder. It may be the case that the diagnosis of the mental disorder was made based on the acceptance criteria of adult units.

9.3.6 Transitional delays

Waiting time to be discharged to forensic adult inpatient services was the most quoted theme in the interviews with healthcare professionals, young people and their carers. Transitional delays accounted for deterioration of

mental health problems, violent incidents on the ward, disengagement from therapeutic relationships and education, isolation, bullying and safeguarding issues. Young people's insight into untimely transitions was limited and was manifested into violent acts and/or social withdrawal. Those young people involved in aggressive behaviour towards staff members and/or peers would be separated and put into seclusion where their symptoms seemed to aggregate. Those young people experiencing isolation would be disengaged from any ward activities and spent the day in their rooms. Parents were worried about prospective transitions and had limited insight and tolerance towards those kinds of service disruptions. Transitional delays mostly accounted for organisational and infrastructural weakness of current services. Both child and adult healthcare professionals had to overcome presenting challenges and facilitate transitions to services. However, delays impacted negatively healthcare professionals, families and young people but they were all affected to different extents. Young people projected their anger and frustrations on members of staff on th ward and then due to safeguarding risks, FCAMHS health providers had to put them in seclusion. The level of risk changed during delayed transitions and FCAMHS healthcare professionals had to identify new placements because community settings would not take over young people with recent violent incidents unready to deal with the challenges in the community.

9.3.7 Age boundary

The age boundary policy on young people moving to adult services once they turn 18 years has been discussed multiple times in the extant literature (Singh *et al.,* 2010). Age criteria should be flexible and pragmatic in terms of meeting young people's needs. As all FCAMHS healthcare professionals highlighted in the interviews, it is quite unrealistic to expect that young people will become adults over a night. At least four of the services reported some flexibility with keeping service users until their 19th birthday. One service pointed out that they were not allowed to keep young people until they turn 19 and they had to expedite the transition process to

meet the commissioning requirements. Funding pressure can be problematic during transition times and can impact transition outcomes negatively. For example, a young person might be transferred to a less suitable placement that does not meet their needs.

Young people moving to forensic adult inpatient services is not assessed by the identified receiving service until the young person has turned 18 years. This process impedes smooth transitions alongside transition preparation. Forensic adult services need to assess young people before they accept them regarding risk presentation. This becomes more of an issue when the young person is decided to step down security level- to move from the medium secure unit to an adult low secure. If the assessment process is delayed, there is uncertainty surrounding the young person's prospective transition. The young person cannot be informed about the date of moving and/or visit the placement. Accordingly, this creates another barrier to the therapeutic relationship of the FCAMHS responsible clinician and the young person. The responsible clinician is perceived as accountable for the young person's situation and therapeutic relationship is damaged since the young person does no longer trust the clinician.

9.3.8 Emerging personality disorders

All young women had emerging personality disorders and presented severe forms of self-harming behaviour. One female patient ended up in a community supported accommodation whereas her support worker reported that she had relapsed and engaged in self-harm. Another female young person could not be managed in an enhanced medium secure unit for adult women and, therefore her responsible clinician had referred her to a higher level of security hospital. Her adult RC stated that the patient was presenting with severe psychotic symptoms and emerging borderline, narcissistic and antisocial personality disorders. One female patient was initially referred to a community placement where she moved once she turned 18. Yet, she was struggling with autonomy and was sent back to

FCAMHS and then referred to a low secure and then again could not be managed there and was admitted to an adult medium secure unit. All these young women presented with comorbid mental health problems and there of them lacked family support during transition resulting in poor transition outcomes. Gendered clinical pathways would significantly facilitate adjustment to adult services. This group of female offenders presents with a set of very special needs that require clinical attention. Severe self-harming increased during periods of transitions and this is an area that needs to be considered from different perspectives. Patients might genuinely engage in self-harming behaviour. However, clinicians and other stake holders should think what serves this act of self-harming especially, in periods of anxiety. Self-harming, as has been mentioned earlier in the literature review of this thesis, could be used as a means of gaining attention and also being treated more leniently. This can be a form of malingering emerging as secondary gain. Manipulative behaviour in clinical settings ensures better treatment and victimises patients seeking to escape from a difficult situation. In this case, some young female offenders may not feel ready to move to adult mental health services and by engaging in self-harming, they can delay their transition and/or change their transition pathway. However, at the moment there is no clinical consensus on how best to address emerging personality disorder needs (Warner *et al.,* 2018).

9.3.9 Parental involvement

Parental involvement was a protective factor for young people's transitions in this research study. However, only in few cases was the parent involved throughout the different stages of transition. Geographical distribution of current national services does not facilitate traveling for parents living on their other side of the country. It has been reported that there is a shortage of hospital units in the southwest of to meet this group's needs (Warner *et al.,* 2018). This unequal distribution of services has further implications on young people and their families and can be linked to poor transition outcomes. Some families cannot visit their children to hospital units frequently due to geographical distance and cannot liaise with FCAMHS

healthcare professionals about the upcoming transition to adult services. This can bring more anxiety to both parents and young people who can be emotionally overwhelmed by the uncertainty that transition to adult services entails.

Young people stated that their parents' or carer's involvement reduced once they moved to adult services. These findings are in line with previous research reporting on limited parental involvement when young people are moving to adult services (Broad *et al.,* 2017). Those young people having their parents involved throughout the transition process had better transition outcomes. FCAMHS aimed to involve the primary carer in the transition process as all healthcare professionals reported even in cases where the parent had lost custody. In certain cases, the parent was not involved because they were disengaged from the very beginning and the social worker would replace their responsibilities along with local authorities and social care. For a few young people, whereas their parents were involved in their care, they had a protective role during transition periods. Young people need a consistent key figure, as most of them will have experienced loss and trauma throughout their lives (Broad *et al.,* 2017).

Parents can facilitate transitions and their involvement in this process is critical for the young peoples' resocialisation and reintegration to the community. However, parents can be a risk factor in young peoples' lives during periods of transition, if they cannot provide adequate care or if they have their own mental health difficulties. Many of these parents have mental health disorders, engage in offending behaviour and reinforce antisocial lifestyles, which have been adopted by their children and have played a role in their care- and criminal-trajectories. The findings from the case note reviews revealed that a number of young people transitioning to adult services and also who had been in contact with the youth justice system from an early age had parents with psychopathology and/or criminal histories. Therefore, parents in these cases are not involved in the

transition process, as healthcare professionals reported, because their involvement could bring additional anxiety to young people.

Those parents being interviewed expressed anxiety about their children's prospective transitions. They were concerned about not being well informed and not being involved enough in the process. One parent felt extremely worried about their child being in limbo and waiting for months and months to be moved. The major concern was about the identified-suggested adult placement that had not formally accepted the young person and the suitability of this service for the vulnerable service user. The family carer felt that this placement would worsen the young person's mental health symptoms and they would not cope in an adult environment due to their developmental age.

Another common theme that all interviewed parents, healthcare professionals and a few young people discussed was geographical location. Parents had to travel a long distance to visit their children either when in FCAMHS or when moving to adult services. The lack of suitable placements for young people with special needs and presentations places them in higher risk of being accommodated far from home. Accordingly, parents cannot visit the placement often and might feel estranged from their children's care and life.

9.3.10 Transition preparation

Transition preparation was quoted multiple times in the interviews with young people as an ongoing problem. Only two young people felt that they were well prepared to move to adult services. Young people who present with high-risk are often not informed about their transition date for safeguarding issues and to prevent any adverse events in the course of transition. Many young people in this research study described their transition as quick and abrupt. Lack of transition preparation emerges from poor liaison with adult mental health services, poor multiagency collaboration, uncertainty about transition destination and the young

person's resistance to accept that they have to leave child services. One patient I tried to recruit for this study and refused to participate twice, when we met to explain the purpose of the study expressed multiple times their resentment on moving to adult services. The responsible clinician recounted that the young person had disengaged from therapeutic work and was strongly attached to child services that she felt not ready to move on. Therefore, she said she would not like to take part in the study because she would not go to adult services and I would not have to visit here there. Transition preparation is not a single event and requires ongoing support from the MDT in each service. It needs to be a collaborative effort between child and adult services with parallel care from both services. However, transition preparation needs to vary and be tailored according to each young person's needs relating to mental disorder, neurodevelopmental difficulties, and risk. Risk presentation can have a strong impact on transition preparation and management. The transition is not only care-driven but driven by protection of the society, past and future victims. Therefore, clinicians need to take risk into serious consideration and plan the transition accordingly. Although a young person may have shown significant improvement mental health-wise, they might still present with high-risk to society and, therefore more weight is given to presenting risk and their transition care-pathway is reflecting their risk needs. If the sentence of these young people has finished and they cannot return to custody, they may still be transferred to forensic adult hospitals to work more on risk reduction.

9.3.11 Continuity of care

The concept of continuity of care can be understood differently for young people moving to the community than those transferring to forensic adult inpatient services. Those returning to the community are diverted from the justice system and need different care than young people remaining in the forensic system. The dynamics of transition depends heavily on the new placement. Presumably, transition for young people moving between secure hospitals is smoother. Young people placed in community settings

from inpatient services need the involvement of multiple services to ensure community integration. However, for young individuals moving to adult medium or high secure hospitals issues surrounding hope could be examined given that their detention in such services might be prolonged.

9.4 Strengths and Limitations

This was the first nationwide study including a forensic adolescent sample. Young people in forensic settings are very unlikely to voice their subjective experiences as they transition from child to adult mental health services (Broad *et al.,* 2017). Transitions in this group have not been studied before at a national level taking into account the difficulties embedded in the recruitment and follow-up processes. Liaising with 15 hospitals and two community settings has been quite challenging along with travelling to 17 geographical locations across England for multiple times. Young people in forensic inpatient services comprise a very small and unique subsample of the youth justice population and present with highly complex needs based on their backgrounds. Healthcare professionals across a wide range of forensic mental health settings voiced their views and experiences on transitions and reported the current organisational and infrastructural weaknesses and challenges in the system as it is currently organised. Healthcare providers from both child and adult services discussed and reflected on key themes that interfere with the discharge process from FCAMHS and parallel care with adult services. Parents and carers were dynamically involved in this project and they played a significant role to conduct of this research study. Those parents who participated, felt empowered to reflect on their children's transition experiences and their contribution to the study, despite the small number of participation, was highly acknowledged, as their views and experiences also shaped the empirical and conceptual contributions of this thesis. This research study adopted both prospective and retrospective designs to retrieve information about different cohorts in inpatient FCAMHS to enable comparisons. Numbers of referrals, clinical and characteristics such as family background have not been looked before nationally. Interviewing

healthcare professionals from child and adult services was very useful in generating and corroborating key themes that should be central to policy decision and clinical practice.

The challenges in recruitment have been cited in existing research alongside the importance of engaging young people in studies (Singh *et al.,* 2010). Responses from clinicians and families varied and ranged from weeks to months that turned recruitment into an even more challenging task. Some young people would share more information than other and all of them had comorbid mental health problems and especially, those with autistic traits and learning difficulties encountered greater difficulty in articulating their thoughts and following the interview discussion.

Families of the young people were not easy to reach due to several reasons, such as geographical location (Dent *et al.,* 2013), lack of involvement and distrust to services. Another challenge was the nature of the offence the young person had committed that might have challenged parental keenness to participate in the study. Families were not always keen to participate, and one explanation might be their hesitancy to share such personal information with a researcher. The most common reason for families not participating was that they would not be responding to invitation letters.

9.5 Future research

Future research should be directed to the prevalence of mental health problems for those young people in forensic inpatient and community units. Young people in secure care present with a set of complex needs and comorbid mental health and neurodevelopmental problems. Emerging personality disorders such as Borderline Personality Disorder (BPD) is a serious concern among young people in inpatient forensic mental health services and the findings of this thesis showed that these young women with persistent emerging personality traits are usually those ore difficult to manage in adult mental health services. More research should be carried

out including female offenders from various secure establishments to understand their needs and level of risk.

A national database for young people in inpatient FCAMHS that is constantly updated would be useful in order to understand the needs of this group up to date. Transition outcomes and preparations should be captured within this database where future research should study the link between index offence and transition outcomes. The current findings revealed that those young people with the most severe mental health symptoms along with serious offences were more likely to have poor transition outcomes. One possible explanation for poor transition outcomes could be offending severity along with other confounding factors such as being abused or have experienced multiple transitions or/and being a looked after child.

There is a need for standardised validated measures particularly designed for forensic populations and targeting the transition processes and outcomes for young offenders in various forensic settings. This research study used a mapping tool and a case note proforma that were initially designed for the TRACK study, which included young people transitioning to adult mental health services in non-forensic contexts. However, the forensic context and the intersection between mental health and medical and legal contexts necessitates the development of new dynamic tools assessing the transition needs and risk of this group moving to forensic and community adult mental health services.

Future research should also involve the victims and/or the victims' families in research studies looking at transition of young offenders discharged to community settings. Transitions of young people with forensic histories have further social implications that pertain to the community as a whole and also to the victims' wellbeing. Community participants may enrich and empower future findings on transition of care in young offenders. Considering that risk to others is a key factor in this group's care-trajectory,

the participation of various stakeholder would facilitate understandings and views on young offenders' release into community settings. Victims' and community's views should not be dismissed, and such research would raise awareness on stigma and inform the public about youth justice system issues and the complex needs this group presents with.

Qualitative research including interviews and focus groups with young people and parents at multiple points of the transition process should be prioritized in future research. The needs of young people and their families change throughout the transition process and should not be treated as being static. Transition is a multifaceted and dynamic process with multiple stages included. Similarly, the needs of the young people at each stage may vary and child and adolescent mental health services in collaboration with adult services should identify and respond to these needs.

In order to improve recruitment for future studies, researchers should aim to work closely with healthcare professionals and the young people. Further, transitions from adolescent low secure units to adult services and to adolescent medium secure services or psychiatric intensive care units comprise potential areas of research. We need more information about transitions from the youth justice system to inpatient FCAMHS and then back to youth custody in order to shed light on the experience of young people experiencing multiple transitions before transitioning to adult mental health services. Prison transfers are very particular in terms of risk and sensitivity. Risks should be more carefully considered including safeguarding in youth justice settings for those young people more susceptible to bullying. Future research should investigate bullying and victimisation incidents by peers and staff in custody settings for those young people transitioning from secure services. However, the young person's best interest should be at the heart of research and clinical practice.

9.6 Recommendations and conclusions

9.6.1 Transition policy in adolescent medium secure units

We have to think beyond the procedural aspects of transitions. There is not a one-size-fits-all model that could be applied to this group of young people. Transition becomes a very personal experience that has a different impact on each young person.

The findings highlight the need for consistency between policy and practice among services along with the development of individualised care pathways. Priority should be given to young people with neurodevelopmental disorders and comorbidity of mental health problems in order to identify appropriate adult services. There is a need for more unified care-schemes across services that will go beyond transition handover planning and will prepare young people through clinical interventions based on their needs. As of now, services struggle with joint working and become disintegrated at times of transition considering the different missions and funding schemes of each service involved in young people's care.

The following recommendations are in line with the *Five Year Forward View for Mental Health* (2016) NHS England programme for 2020/21. The NHS is in the process of improving existing services by prioritising children and young people. This programme will *implement* new care models to improve outcomes for Looked After Children (LAC), young people in the youth justice system, and those in specialised inpatient units along with those with autism and learning disabilities. The NHS England (2016) is committed to break down the one-size-fits-all model to improve care provision and integrate more frameworks of care in order to build sustainable services. As of now, more weight has been given on improving and empowering services, whilst from now we should invest in empowering young people and services should echo their needs. Young people should

be involved in co-producing their care plans along with the healthcare key figure they have built a trusting relationship. Making sense of their life story by constructing a narrative would increase insight and help to focus on the protective factors in place. For instance, the principles of the Good Lives Model and Risk Needs Responsivity frameworks are underlined by a *strength-based approach.* This framework takes into consideration the whole life story of the young person instead of solely focussing on the offence (Fortune, 2017). GLM and RNR aim to facilitate the process of rehabilitation and resocialisation for young people. Understanding the personal circumstances of each young person including the presence of risk factors at the time of the offence, can help young people to build on protective factors by promoting their strengths. Reintegration to the community is an ongoing process, as transitions of care and should be gradual to benefit the young people, their families, victims and the public. Young people with forensic histories returning to the community is also a social concern that has further implications on the community. Therefore, transition preparation extends to the community and the victims and/or the victims' families who should not be overlooked. Their needs should be acknowledged and considered when moving young people back to their communities.

Table 21. Transition policy recommendations for young people discharged from FCAMHS

- Transition guidelines should provide care framework when beds are not available in adult forensic hospitals.
- Transition guidelines and/or protocols should be designed for all medium secure adolescent units.
- Separate guidelines should be used for high-risk cases.
- Guidelines should be designed to provide alternatives for those young people not accepted by community services due to their index offence and forensic history and risk.
- Forensic and generic hospitals should have separate sections for younger groups of patients based on their needs.
- There should be additional units for emerging adults aged between 19 and 24 years.
- Specific documents and guidelines should be designed for the young people and their families about transition steps and processes.
- Young people and their families should be included in co-production of forming transition guidelines.
- Young people and families with current or past lived experience of service use should be used in the design of these guidelines.
- More funding resources should be available to be allocated for transitions to turn transition preparation into a planned and gradual process.
- The period of *letting go of* child services should be extended for those young people who would benefit from staying longer than the age transition boundary allows them.
- Age flexibility needs to be at the top of the transformation agenda.
- More pathways should be created in the community or other residential accommodations tailored for this group's needs.
- More funding should be allocated to child services for visiting young people at least 6 months post-transition.
- There should not be any children and/or adolescents on adult wards.

- Gendered distinct care pathways should be designed focussing on emerging personality disorders and self-harming behaviour.
- Follow up visits to adult services from by key figures from young people's child-care would benefit young people and will facilitate therapeutic relationship endings.
- Education services should be improved to facilitate young people's reintegration into their communities.
- Public awareness should be raised to avoid stigma, labelling and bullying of young people and to allow them to return to their home communities.
- There should be more funding available to child services and community settings to train young people towards an independent lifestyle.
- Young people should move to their catchment areas and funding issues should not become an obstacle.
- Restorative justice approaches should be used to reintegrate young people to the community without overlooking victims' needs.
- The local authorities from the young person's home area should be actively involved from the beginning of the transition.
- Transition teams need to be established in both child and adult services that will work jointly and facilitate the young people's transition process from the beginning to the end.
- There should be at least one key figure from child services and one from adult services that will have a sustainable therapeutic relationship with the young person.
- Adult services should invest more in trauma-informed care by approaching a developmental perspective towards the young person.

Table 22. Clinical practice recommendations for young people discharged from FCAMHS

- Adopt a person-centred approach that places young people at the heart of clinical practice and avoid unimodal interventions that disregard the multiple needs of this group.
- Clinicians in child services should aim for less transitions to adult forensic hospitals and invest more in good transition planning and preparation for community and residential settings.
- Clinicians in child services should aim for more pragmatic practices by investing in education and vocational training and creative activities (e.g. music/dance/yoga lessons) during transition preparation.
- Clinicians in child services should organise interactive transition workshops and seminars that will explain the different stages involved in independent living.
- Clinicians in child services should promote multiagency collaboration by ongoing support and communication with key healthcare workers from the receiving service.
- Meetings between healthcare professionals from same and different professions should be facilitated from both child and adult services alongside meetings with the young people, their families and the key workers from the adult service.
- Careful consideration should be paid to the most vulnerable young people such as those with neurodevelopmental needs and learning difficulties.
- Clinicians should aim for more parental involvement or at least one key figure that will be consistent across the young person's transition process.
- Family and parents and/or carers should be involved in all transition stages and in co-production of the care planning.
- The young people should also be able to be listened to by the MDT and play an active role in shaping their care planning

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Wright, S. & Liddle, M. (2014) Young offenders and trauma: experience and impact. *A Practitioner's Guide, Beyond Youth Custody*.

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YoungMinds (2013) *Same Old... the experiences of young offenders with mental health needs.* London: YoungMinds.

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Young, S. & Thome, J. (2011) ADHD and offenders. *The World Journal of Biological Psychiatry,* 12 (sup1): 124-128.

Young, S., Sedgwick, O., Fridman, M., Gudjonsson, G., Hodgkins, P., Lantigua, M. & González, R. A. (2015) Co-morbid psychiatric disorders among incarcerated 57 ADHD populations: a meta-analysis. *Psychological medicine,* 1-12.

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11. Appendices

Appendix 1.Search terms for systematic review

mental health AND young offenders
mental disorders AND prevalence AND adolescents AND Juvenile delinquency
depression AND juvenile offenders
conduct disorder AND young offenders
detained youth AND mental health
personality disorders AND young offenders
suicid* behavior AND young offen*
ADHD AND young offen*
psych* disorders AND young offen*
learning dis* AND young offen*
anxiety dis* ANDyoung offen*
juven* offen* AND mental dis*
juven* del* AND mental dis*

Appendix 2. Critical Appraisal Checklist for Meta-analysis

JBI Critical Appraisal Checklist for Studies Reporting Prevalence Data

Reviewer_____Date_____

Author _____Year_____Record Number_____

		Yes	No	Unclear	Not applicable
1.	Was the sample frame appropriate to address the target population?	☐	☐	☐	☐
2.	Were study participants sampled in an appropriate way?	☐	☐	☐	☐
3.	Was the sample size adequate?	☐	☐	☐	☐
4.	Were the study subjects and the setting described in detail?	☐	☐	☐	☐
5.	Was the data analysis conducted with sufficient coverage of the identified sample?	☐	☐	☐	☐
6.	Were valid methods used for the identification of the condition?	☐	☐	☐	☐
7.	Was the condition measured in a standard, reliable way for all participants?	☐	☐	☐	☐
8.	Was there appropriate statistical analysis?	☐	☐	☐	☐
9.	Was the response rate adequate, and if not, was the low response rate managed appropriately?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

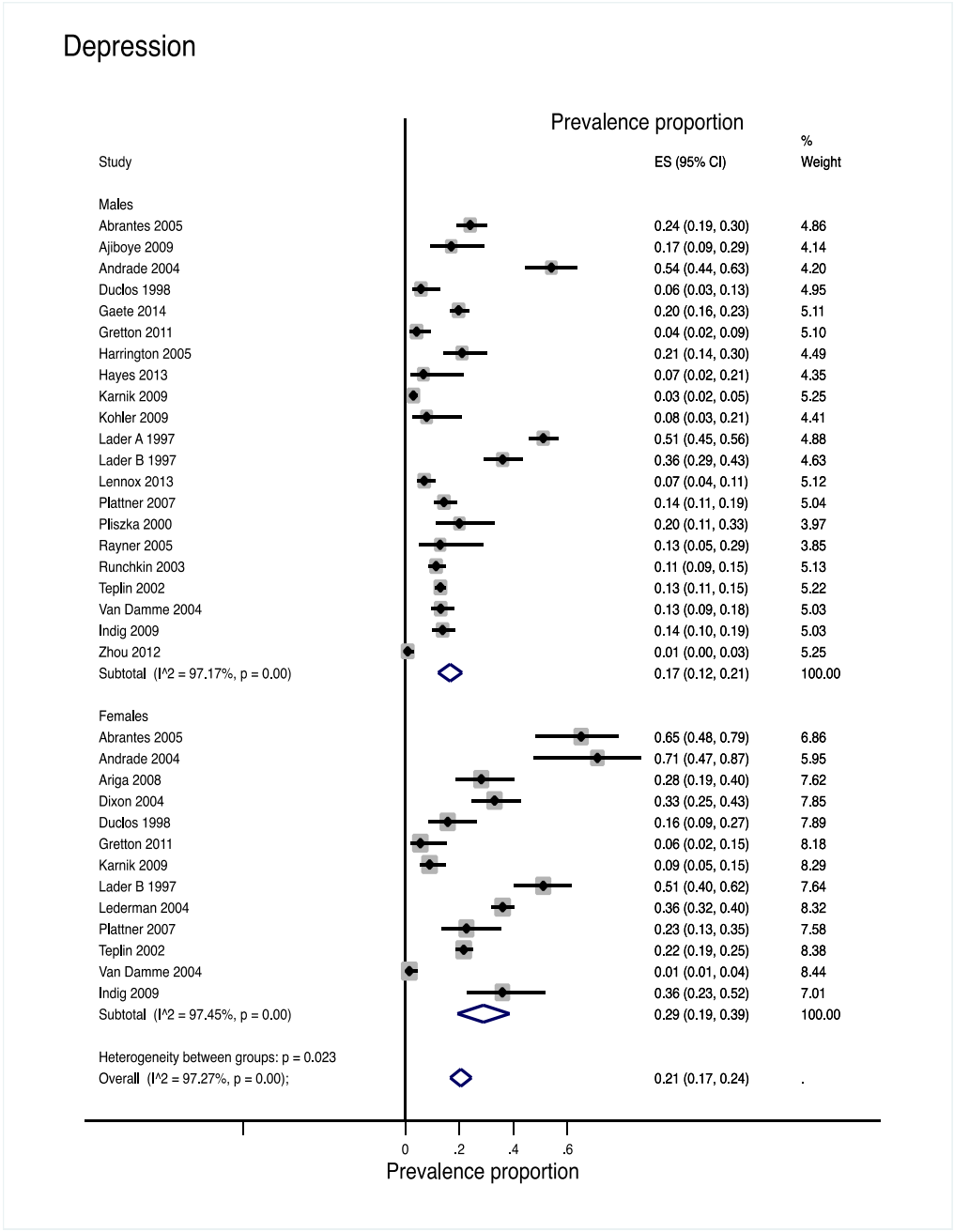
Appendix 3. Table summarising quality assessment of 30 studies.

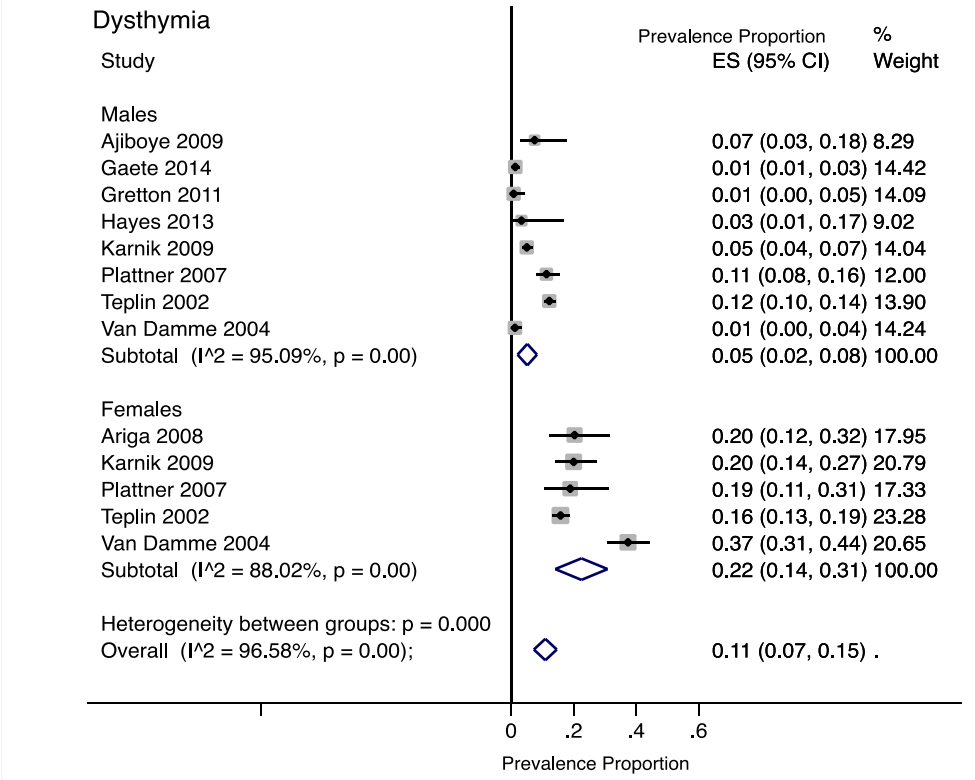
Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Abrantes	Y	Y	U	Y	U	Y	Y	Y	U	N
Ajiboye	Y	Y	N	Y	U	Y	Y	Y	N	Y
Andrade	Y	Y	Y	Y	U	Y	N	Y	U	Y
Ariga	Y	Y	N	Y	Y	Y	Y	Y	N	N
Caufmann	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Dixon	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Duclos	Y	Y	Y	Y	U	Y	Y	Y	Y	U
Eppright	Y	Y	Y	U	U	Y	Y	Y	Y	Y
Gaete	Y	Y	Y	U	Y	Y	Y	Y	U	U
Gosden	Y	Y	Y	Y	U	Y	Y	Y	U	Y
Gretton	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Harrington	Y	Y	Y	Y	U	Y	N	Y	N	Y
Hayes	N	Y	N	Y	Y	Y	Y	Y	N	N
Howard	N	Y	Y	Y	Y	Y	Y	Y	N	N
Indig	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Karnik	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Kohler	N	N	Y	Y	Y	Y	Y	Y	N	Y
Lader	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Lederman	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Lennox	N	Y	N	Y	Y	Y	Y	Y	Y	Y
Plattner	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Pliszka	Y	N	Y	N	U	Y	Y	Y	U	U
Rayner	Y	Y	Y	N	U	Y	Y	Y	U	N
Runchkin	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Steiner	N	Y	N	Y	N	Y	Y	Y	Y	Y
Teplin	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Timmons	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Van Damme	Y	Y	Y	Y	U	Y	Y	Y	Y	Y
Vreugdenhil	Y	Y	Y	Y	Y	Y	Y	Y	N	U
Zhou	Y	Y	Y	Y	U	Y	Y	Y	Y	Y

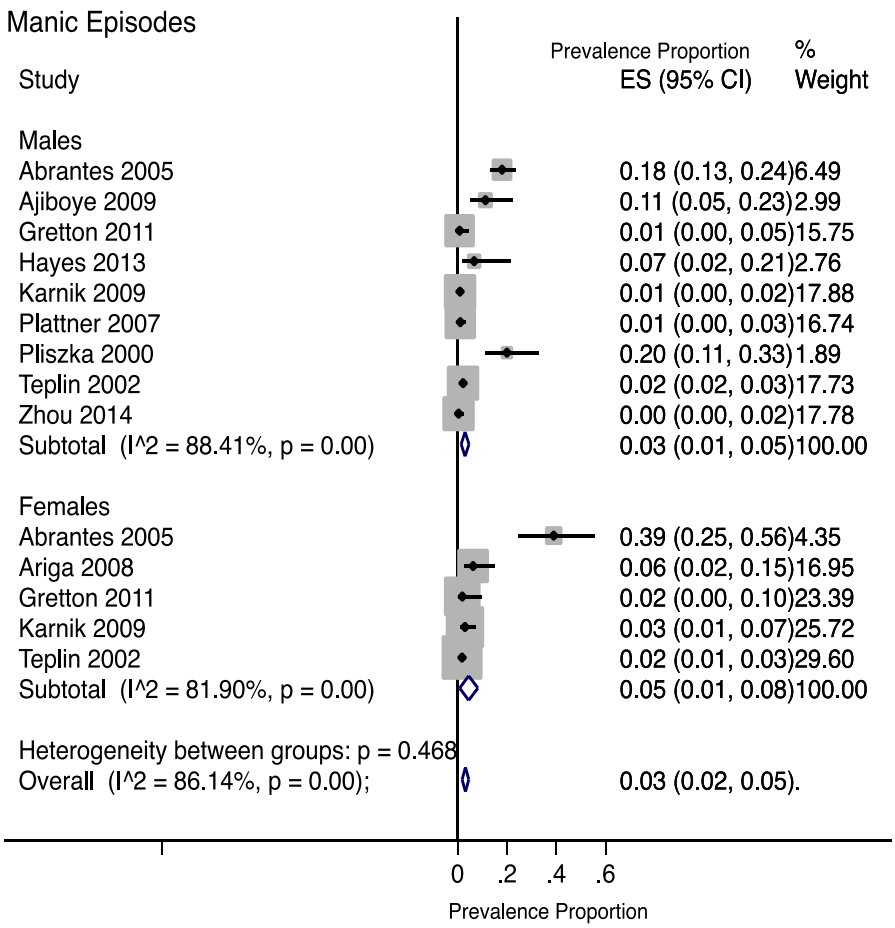
This table displays the reviewers' answers to quality assessment questions.
The highest score was 10 for a study that met all quality assessment criteria.

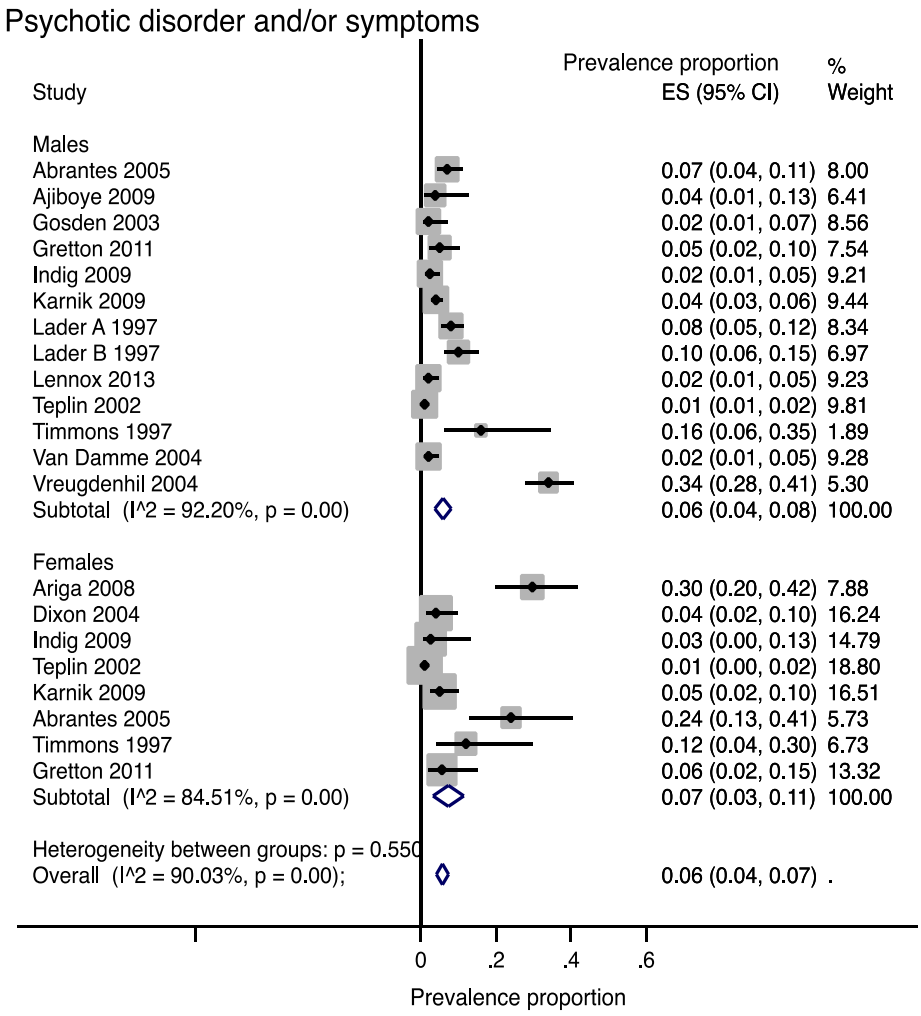
Y=yes; N=no; U=unknown

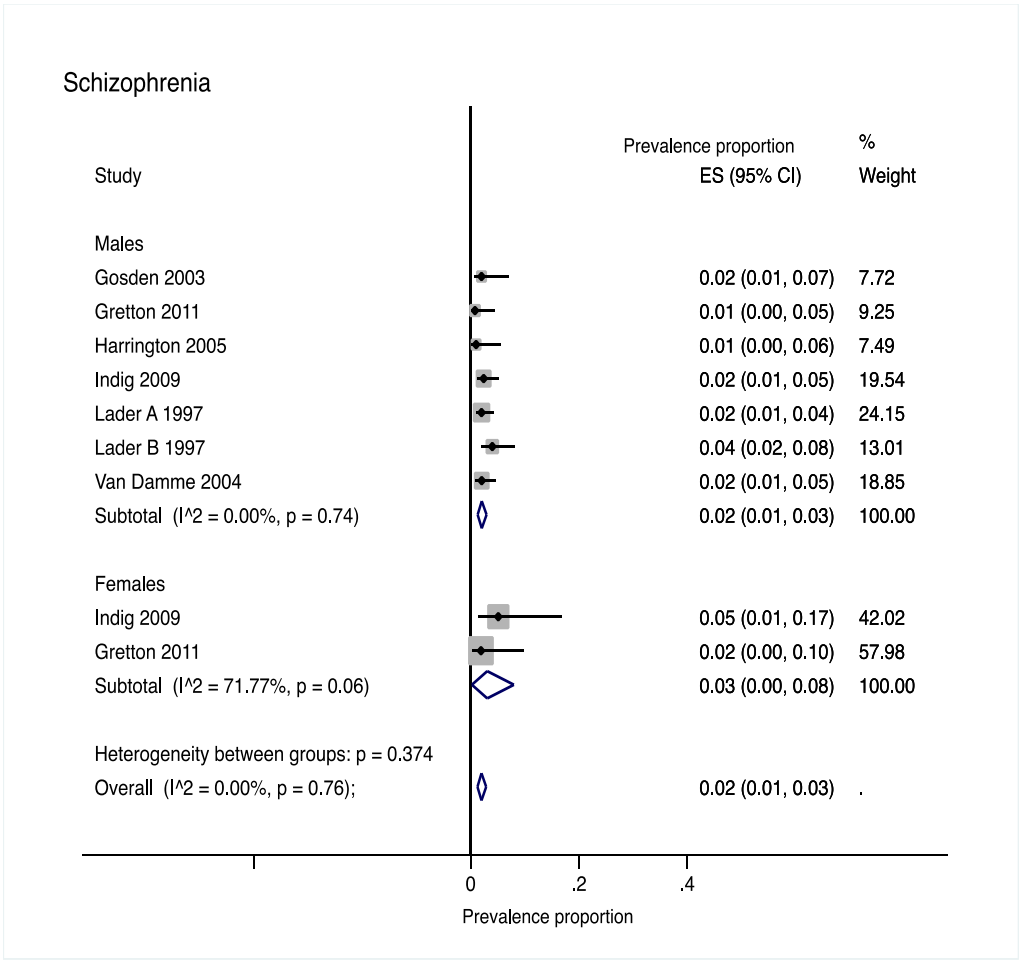
Appendix 4. Forest plots

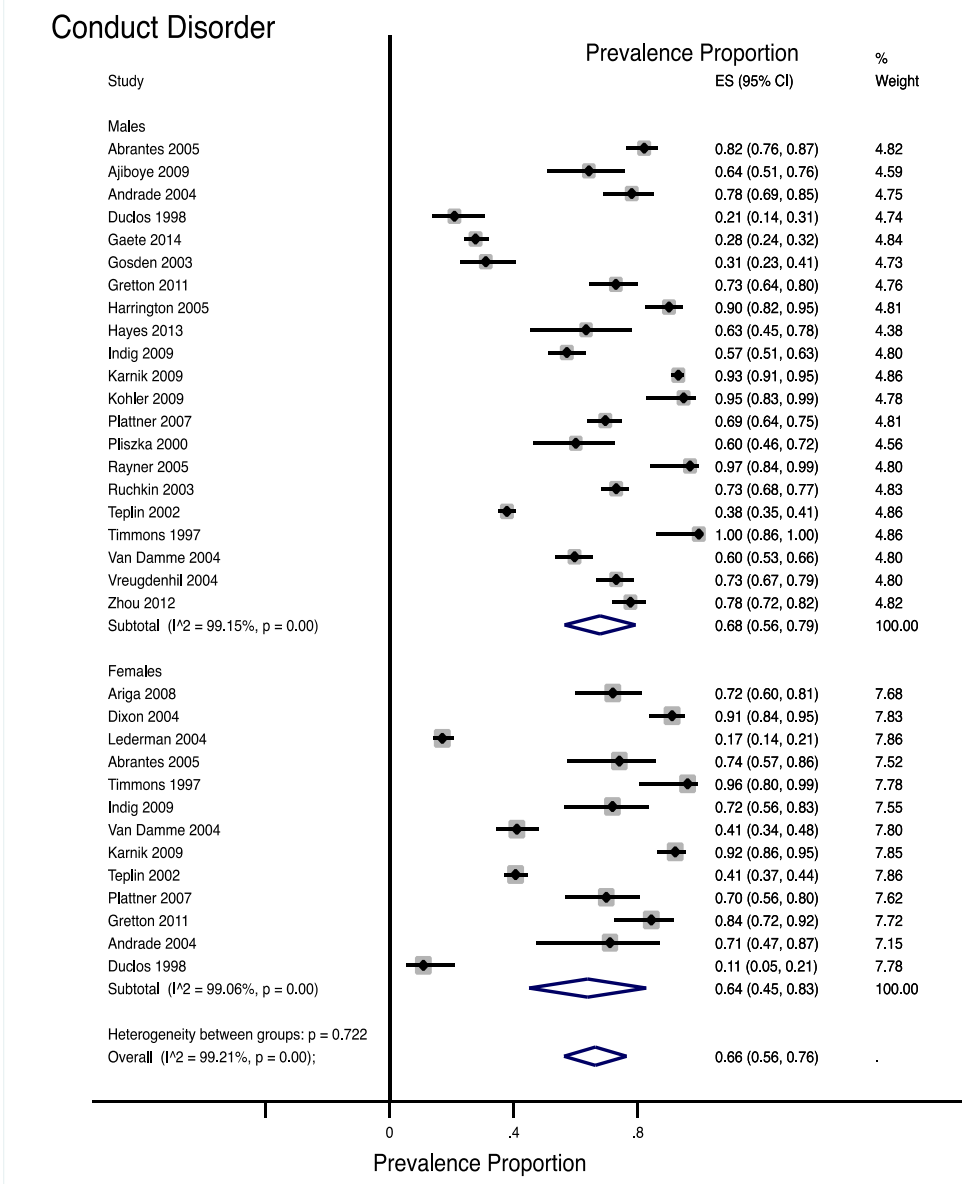



Dysthymia
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Ajiboye 2009 0.07 (0.03, 0.18) 8.29
Gaete 2014 0.01 (0.01, 0.03) 14.42
Gretton 2011 0.01 (0.00, 0.05) 14.09
Hayes 2013 0.03 (0.01, 0.17) 9.02
Karnik 2009 0.05 (0.04, 0.07) 14.04
Plattner 2007 0.11 (0.08, 0.16) 12.00
Teplin 2002 0.12 (0.10, 0.14) 13.90
Van Damme 2004 0.01 (0.00, 0.04) 14.24
Subtotal (I^2 = 95.09%, p = 0.00) 0.05 (0.02, 0.08) 100.00
Females
Ariga 2008 0.20 (0.12, 0.32) 17.95
Karnik 2009 0.20 (0.14, 0.27) 20.79
Plattner 2007 0.19 (0.11, 0.31) 17.33
Teplin 2002 0.16 (0.13, 0.19) 23.28
Van Damme 2004 0.37 (0.31, 0.44) 20.65
Subtotal (I^2 = 88.02%, p = 0.00) 0.22 (0.14, 0.31) 100.00
Heterogeneity between groups: p = 0.000
Overall (I^2 = 96.58%, p = 0.00); 0.11 (0.07, 0.15) .
0
.2
.4
.6
Prevalence Proportion

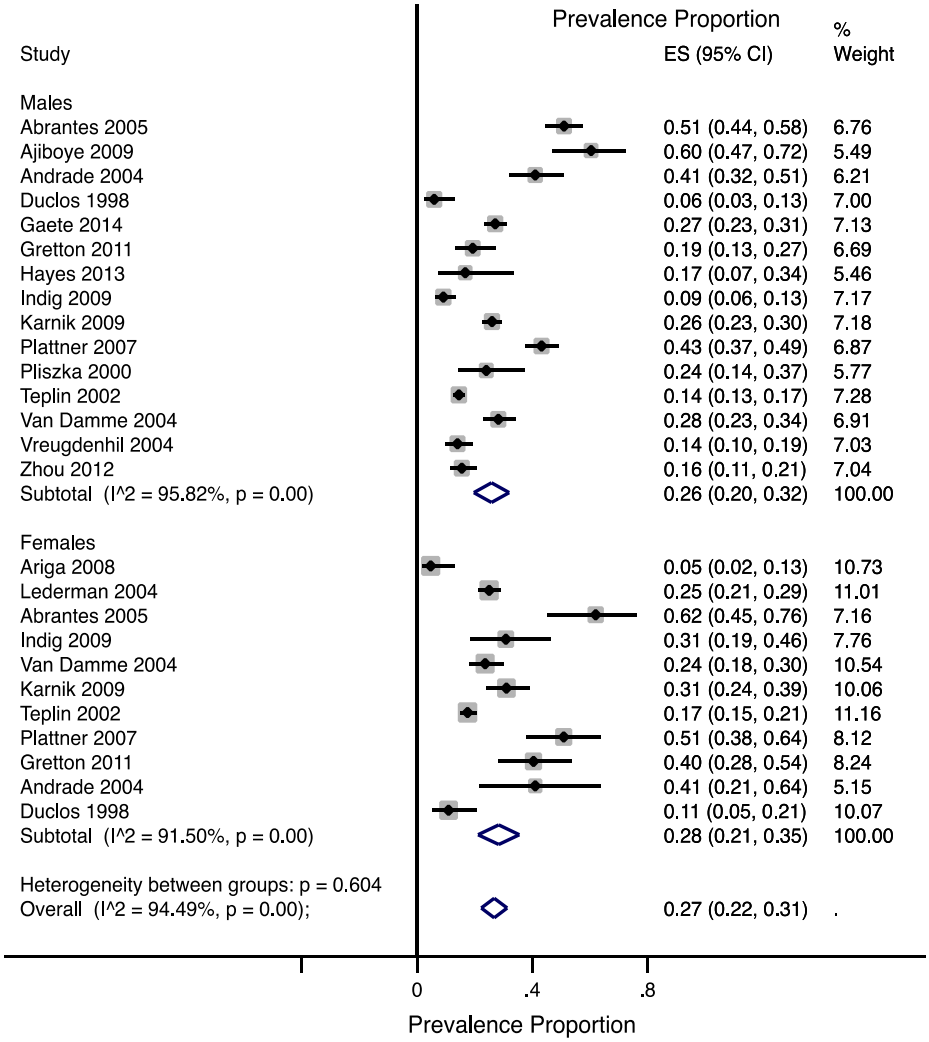

Manic Episodes
Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Abrantes 2005 0.18 (0.13, 0.24) 6.49
Ajiboye 2009 0.11 (0.05, 0.23) 2.99
Gretton 2011 0.01 (0.00, 0.05) 15.75
Hayes 2013 0.07 (0.02, 0.21) 2.76
Karnik 2009 0.01 (0.00, 0.02) 17.88
Plattner 2007 0.01 (0.00, 0.03) 16.74
Pliszka 2000 0.20 (0.11, 0.33) 1.89
Teplin 2002 0.02 (0.02, 0.03) 17.73
Zhou 2014 0.00 (0.00, 0.02) 17.78
Subtotal (I^2 = 88.41%, p = 0.00) 0.03 (0.01, 0.05) 100.00
Females
Abrantes 2005 0.39 (0.25, 0.56) 4.35
Ariga 2008 0.06 (0.02, 0.15) 16.95
Gretton 2011 0.02 (0.00, 0.10) 23.39
Karnik 2009 0.03 (0.01, 0.07) 25.72
Teplin 2002 0.02 (0.01, 0.03) 29.60
Subtotal (I^2 = 81.90%, p = 0.00) 0.05 (0.01, 0.08) 100.00
Heterogeneity between groups: p = 0.468
Overall (I^2 = 86.14%, p = 0.00); 0.03 (0.02, 0.05).
0
.2
.4
.6
Prevalence Proportion

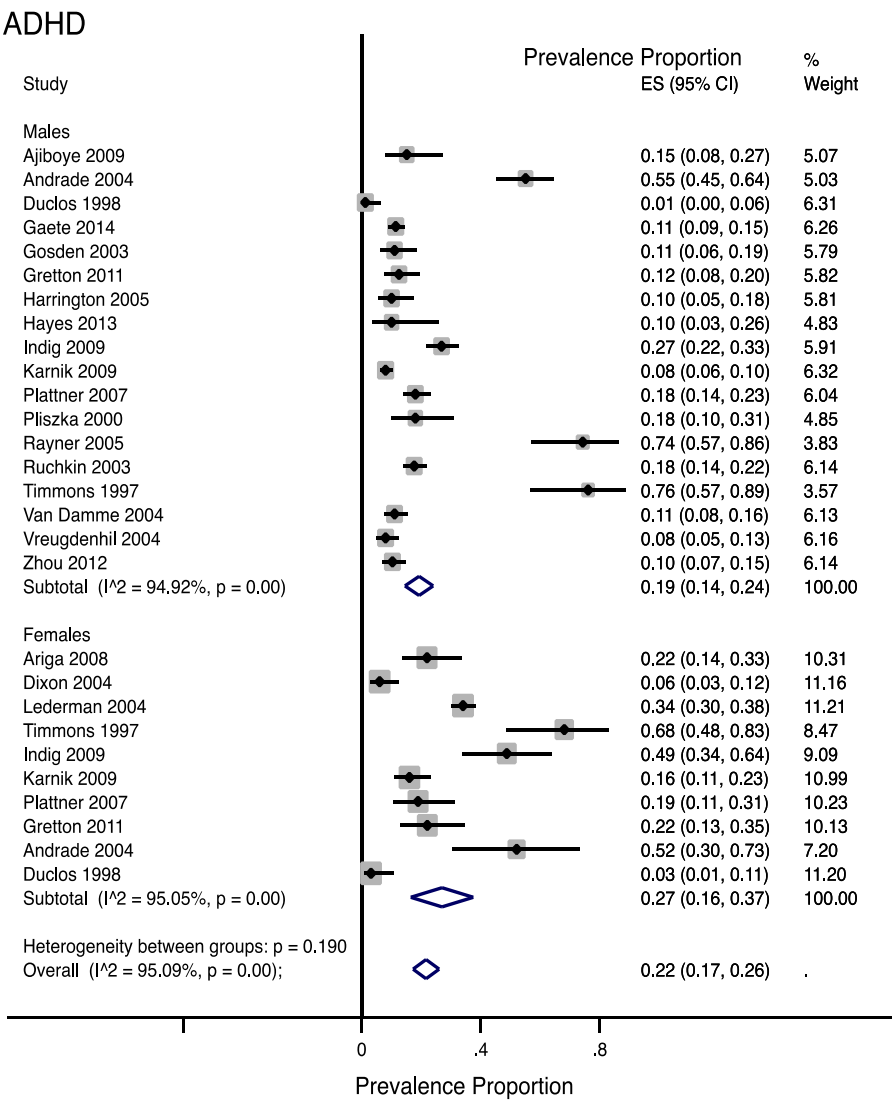

Psychotic disorder and/or symptoms
Study
Prevalence proportion
ES (95% CI)
%
Weight
Males
Abrantes 2005 0.07 (0.04, 0.11) 8.00
Ajiboye 2009 0.04 (0.01, 0.13) 6.41
Gosden 2003 0.02 (0.01, 0.07) 8.56
Gretton 2011 0.05 (0.02, 0.10) 7.54
Indig 2009 0.02 (0.01, 0.05) 9.21
Karnik 2009 0.04 (0.03, 0.06) 9.44
Lader A 1997 0.08 (0.05, 0.12) 8.34
Lader B 1997 0.10 (0.06, 0.15) 6.97
Lennox 2013 0.02 (0.01, 0.05) 9.23
Teplin 2002 0.01 (0.01, 0.02) 9.81
Timmons 1997 0.16 (0.06, 0.35) 1.89
Van Damme 2004 0.02 (0.01, 0.05) 9.28
Vreugdenhil 2004 0.34 (0.28, 0.41) 5.30
Subtotal (I^2 = 92.20%, p = 0.00) 0.06 (0.04, 0.08) 100.00
Females
Ariga 2008 0.30 (0.20, 0.42) 7.88
Dixon 2004 0.04 (0.02, 0.10) 16.24
Indig 2009 0.03 (0.00, 0.13) 14.79
Teplin 2002 0.01 (0.00, 0.02) 18.80
Karnik 2009 0.05 (0.02, 0.10) 16.51
Abrantes 2005 0.24 (0.13, 0.41) 5.73
Timmons 1997 0.12 (0.04, 0.30) 6.73
Gretton 2011 0.06 (0.02, 0.15) 13.32
Subtotal (I^2 = 84.51%, p = 0.00) 0.07 (0.03, 0.11) 100.00
Heterogeneity between groups: p = 0.550
Overall (I^2 = 90.03%, p = 0.00); 0.06 (0.04, 0.07) .
0
.2
.4
.6
Prevalence proportion

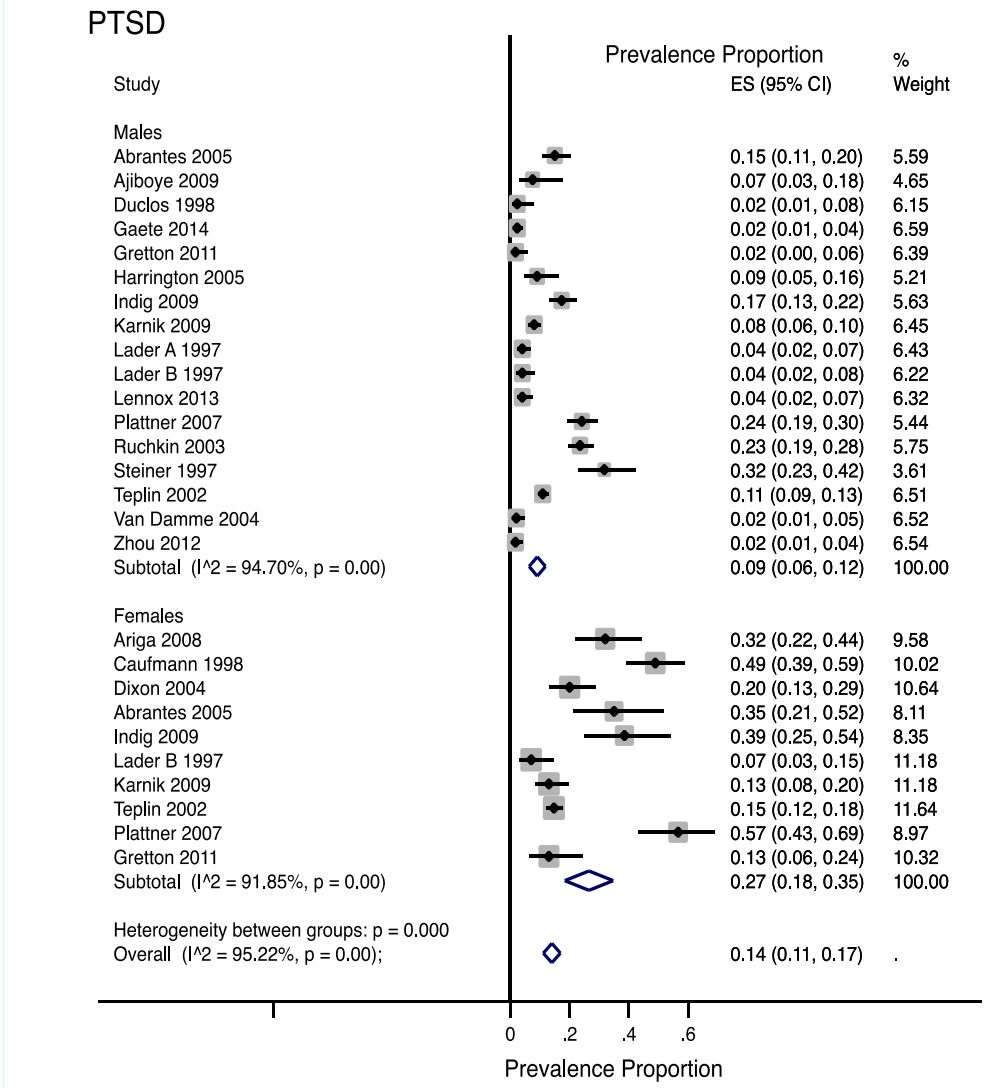

Schizophrenia
Study
Prevalence proportion
ES (95% CI)
%
Weight
Males
Gosden 2003
0.02 (0.01, 0.07)
7.72
Gretton 2011
0.01 (0.00, 0.05)
9.25
Harrington 2005
0.01 (0.00, 0.06)
7.49
Indig 2009
0.02 (0.01, 0.05)
19.54
Lader A 1997
0.02 (0.01, 0.04)
24.15
Lader B 1997
0.04 (0.02, 0.08)
13.01
Van Damme 2004
0.02 (0.01, 0.05)
18.85
Subtotal (I^2 = 0.00%, p = 0.74)
0.02 (0.01, 0.03)
100.00
Females
Indig 2009
0.05 (0.01, 0.17)
42.02
Gretton 2011
0.02 (0.00, 0.10)
57.98
Subtotal (I^2 = 71.77%, p = 0.06)
0.03 (0.00, 0.08)
100.00
Heterogeneity between groups: p = 0.374
Overall (I^2 = 0.00%, p = 0.76);
0.02 (0.01, 0.03)
.
0
.2
.4
Prevalence proportion

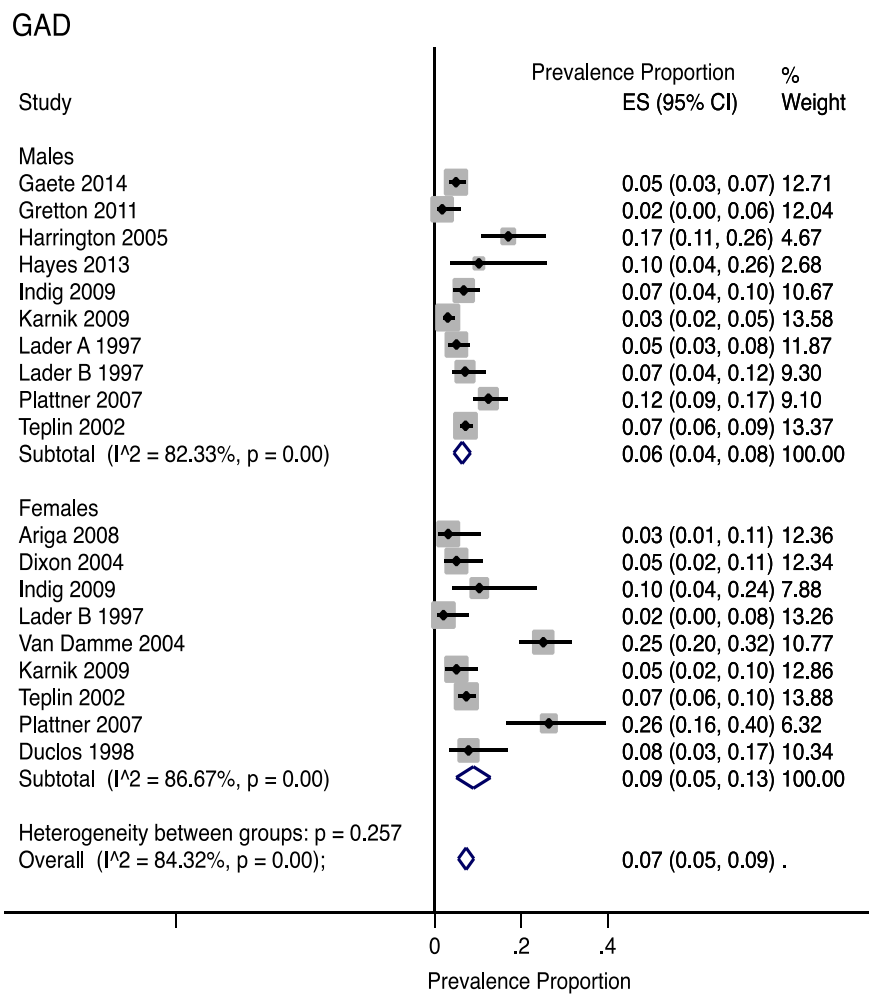

Conduct Disorder
Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Abrantes 2005 0.82 (0.76, 0.87) 4.82
Ajiboye 2009 0.64 (0.51, 0.76) 4.59
Andrade 2004 0.78 (0.69, 0.85) 4.75
Duclos 1998 0.21 (0.14, 0.31) 4.74
Gaete 2014 0.28 (0.24, 0.32) 4.84
Gosden 2003 0.31 (0.23, 0.41) 4.73
Gretton 2011 0.73 (0.64, 0.80) 4.76
Harrington 2005 0.90 (0.82, 0.95) 4.81
Hayes 2013 0.63 (0.45, 0.78) 4.38
Indig 2009 0.57 (0.51, 0.63) 4.80
Karnik 2009 0.93 (0.91, 0.95) 4.86
Kohler 2009 0.95 (0.83, 0.99) 4.78
Plattner 2007 0.69 (0.64, 0.75) 4.81
Pliszka 2000 0.60 (0.46, 0.72) 4.56
Rayner 2005 0.97 (0.84, 0.99) 4.80
Ruchkin 2003 0.73 (0.68, 0.77) 4.83
Teplin 2002 0.38 (0.35, 0.41) 4.86
Timmons 1997 1.00 (0.86, 1.00) 4.86
Van Damme 2004 0.60 (0.53, 0.66) 4.80
Vreugdenhil 2004 0.73 (0.67, 0.79) 4.80
Zhou 2012 0.78 (0.72, 0.82) 4.82
Subtotal (I^2 = 99.15%, p = 0.00) 0.68 (0.56, 0.79) 100.00
Females
Ariga 2008 0.72 (0.60, 0.81) 7.68
Dixon 2004 0.91 (0.84, 0.95) 7.83
Lederman 2004 0.17 (0.14, 0.21) 7.86
Abrantes 2005 0.74 (0.57, 0.86) 7.52
Timmons 1997 0.96 (0.80, 0.99) 7.78
Indig 2009 0.72 (0.56, 0.83) 7.55
Van Damme 2004 0.41 (0.34, 0.48) 7.80
Karnik 2009 0.92 (0.86, 0.95) 7.85
Teplin 2002 0.41 (0.37, 0.44) 7.86
Plattner 2007 0.70 (0.56, 0.80) 7.62
Gretton 2011 0.84 (0.72, 0.92) 7.72
Andrade 2004 0.71 (0.47, 0.87) 7.15
Duclos 1998 0.11 (0.05, 0.21) 7.78
Subtotal (I^2 = 99.06%, p = 0.00) 0.64 (0.45, 0.83) 100.00
Heterogeneity between groups: p = 0.722
Overall (I^2 = 99.21%, p = 0.00); 0.66 (0.56, 0.76) .
0
.4
.8
Prevalence Proportion

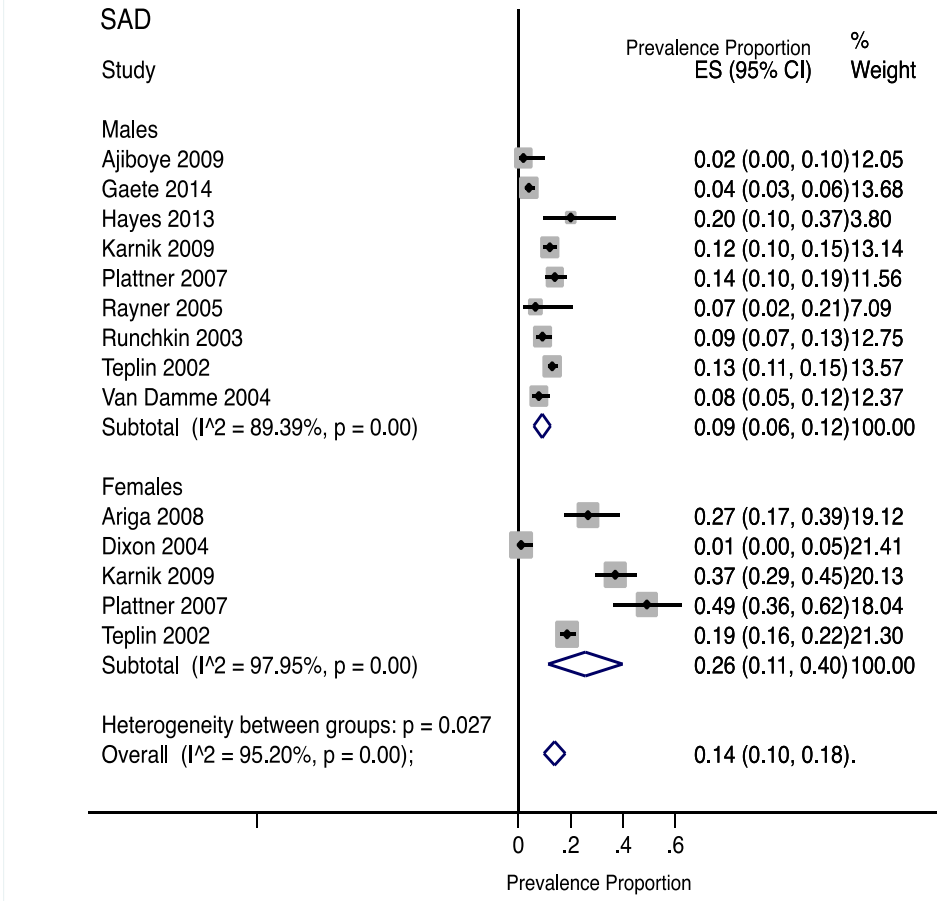
ODD

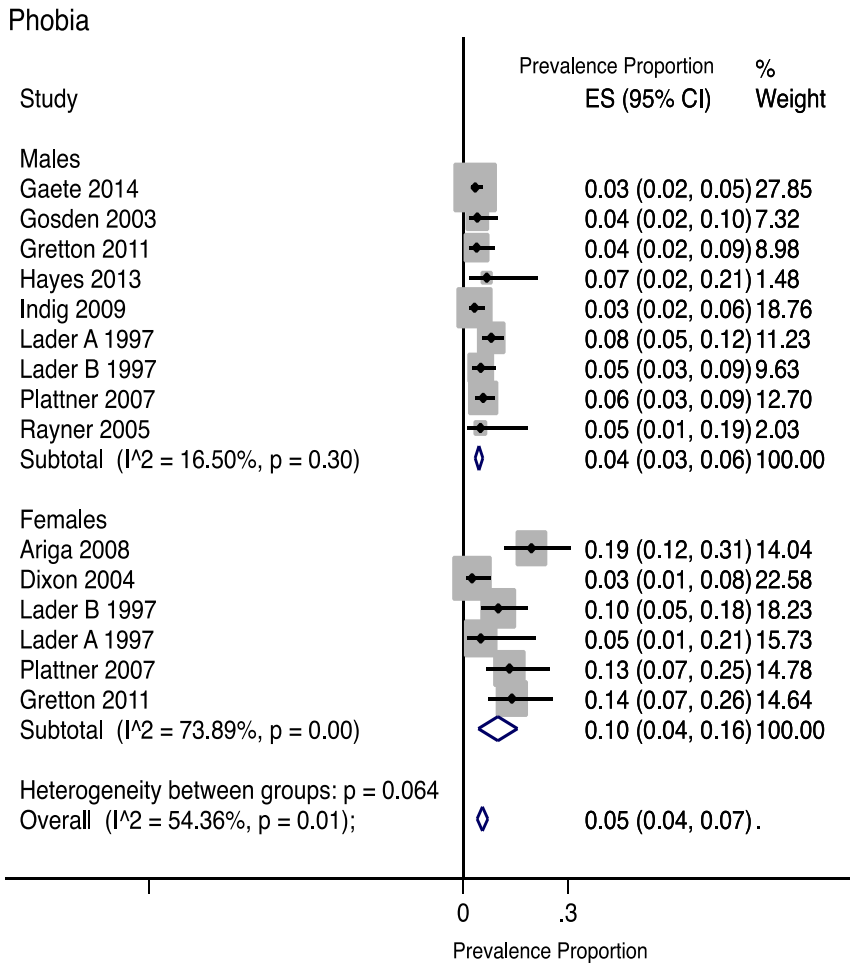

Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Abrantes 2005 0.51 (0.44, 0.58) 6.76
Ajiboye 2009 0.60 (0.47, 0.72) 5.49
Andrade 2004 0.41 (0.32, 0.51) 6.21
Duclos 1998 0.06 (0.03, 0.13) 7.00
Gaete 2014 0.27 (0.23, 0.31) 7.13
Gretton 2011 0.19 (0.13, 0.27) 6.69
Hayes 2013 0.17 (0.07, 0.34) 5.46
Indig 2009 0.09 (0.06, 0.13) 7.17
Karnik 2009 0.26 (0.23, 0.30) 7.18
Plattner 2007 0.43 (0.37, 0.49) 6.87
Pliszka 2000 0.24 (0.14, 0.37) 5.77
Teplin 2002 0.14 (0.13, 0.17) 7.28
Van Damme 2004 0.28 (0.23, 0.34) 6.91
Vreugdenhil 2004 0.14 (0.10, 0.19) 7.03
Zhou 2012 0.16 (0.11, 0.21) 7.04
Subtotal (I^2 = 95.82%, p = 0.00) 0.26 (0.20, 0.32) 100.00
Females
Ariga 2008 0.05 (0.02, 0.13) 10.73
Lederman 2004 0.25 (0.21, 0.29) 11.01
Abrantes 2005 0.62 (0.45, 0.76) 7.16
Indig 2009 0.31 (0.19, 0.46) 7.76
Van Damme 2004 0.24 (0.18, 0.30) 10.54
Karnik 2009 0.31 (0.24, 0.39) 10.06
Teplin 2002 0.17 (0.15, 0.21) 11.16
Plattner 2007 0.51 (0.38, 0.64) 8.12
Gretton 2011 0.40 (0.28, 0.54) 8.24
Andrade 2004 0.41 (0.21, 0.64) 5.15
Duclos 1998 0.11 (0.05, 0.21) 10.07
Subtotal (I^2 = 91.50%, p = 0.00) 0.28 (0.21, 0.35) 100.00
Heterogeneity between groups: p = 0.604
Overall (I^2 = 94.49%, p = 0.00); 0.27 (0.22, 0.31) .
0
.4
.8
Prevalence Proportion

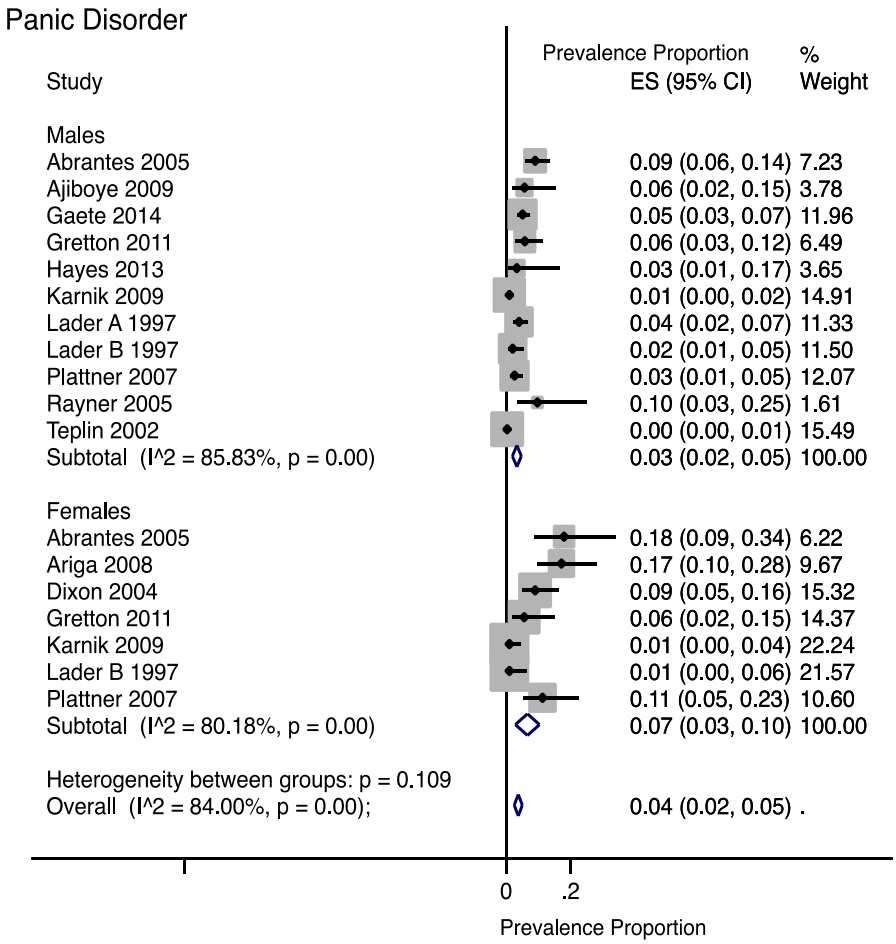

ADHD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Ajiboye 2009 0.15 (0.08, 0.27) 5.07
Andrade 2004 0.55 (0.45, 0.64) 5.03
Duclos 1998 0.01 (0.00, 0.06) 6.31
Gaete 2014 0.11 (0.09, 0.15) 6.26
Gosden 2003 0.11 (0.06, 0.19) 5.79
Gretton 2011 0.12 (0.08, 0.20) 5.82
Harrington 2005 0.10 (0.05, 0.18) 5.81
Hayes 2013 0.10 (0.03, 0.26) 4.83
Indig 2009 0.27 (0.22, 0.33) 5.91
Karnik 2009 0.08 (0.06, 0.10) 6.32
Plattner 2007 0.18 (0.14, 0.23) 6.04
Pliszka 2000 0.18 (0.10, 0.31) 4.85
Rayner 2005 0.74 (0.57, 0.86) 3.83
Ruchkin 2003 0.18 (0.14, 0.22) 6.14
Timmons 1997 0.76 (0.57, 0.89) 3.57
Van Damme 2004 0.11 (0.08, 0.16) 6.13
Vreugdenhil 2004 0.08 (0.05, 0.13) 6.16
Zhou 2012 0.10 (0.07, 0.15) 6.14
Subtotal (I^2 = 94.92%, p = 0.00) 0.19 (0.14, 0.24) 100.00
Females
Ariga 2008 0.22 (0.14, 0.33) 10.31
Dixon 2004 0.06 (0.03, 0.12) 11.16
Lederman 2004 0.34 (0.30, 0.38) 11.21
Timmons 1997 0.68 (0.48, 0.83) 8.47
Indig 2009 0.49 (0.34, 0.64) 9.09
Karnik 2009 0.16 (0.11, 0.23) 10.99
Plattner 2007 0.19 (0.11, 0.31) 10.23
Gretton 2011 0.22 (0.13, 0.35) 10.13
Andrade 2004 0.52 (0.30, 0.73) 7.20
Duclos 1998 0.03 (0.01, 0.11) 11.20
Subtotal (I^2 = 95.05%, p = 0.00) 0.27 (0.16, 0.37) 100.00
Heterogeneity between groups: p = 0.190
Overall (I^2 = 95.09%, p = 0.00); 0.22 (0.17, 0.26) .
0
.4
.8
Prevalence Proportion

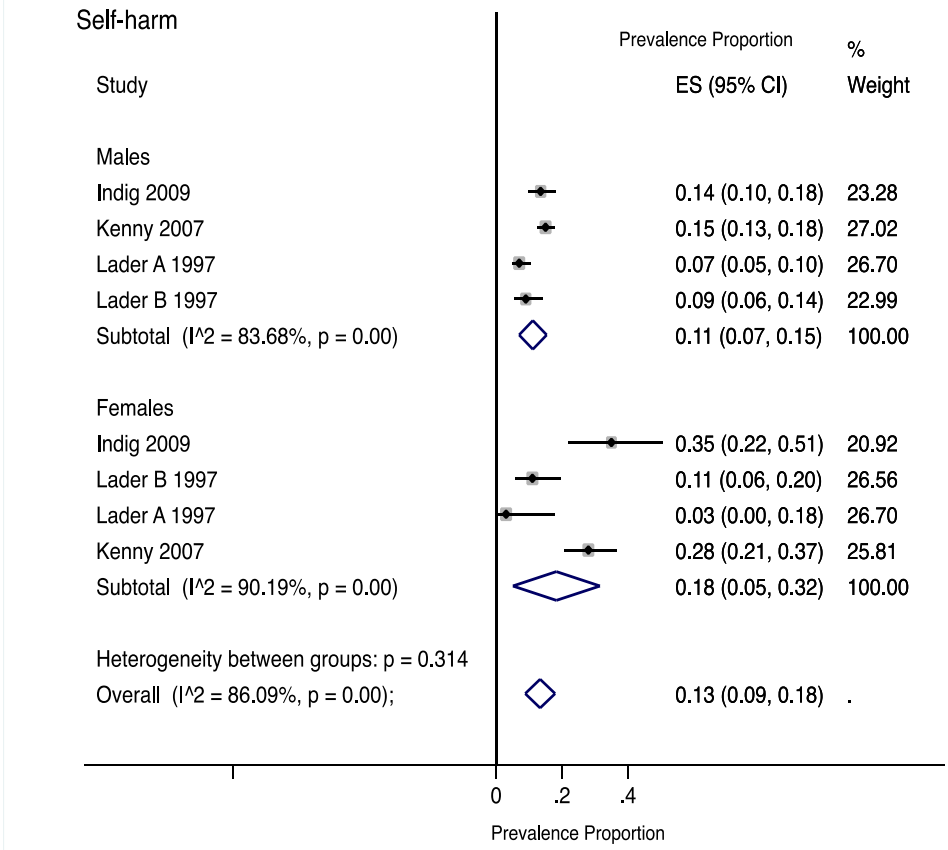

PTSD
Prevalence Proportion
Study
ES (95% CI)
% Weight
Males
Abrantes 2005 0.15 (0.11, 0.20) 5.59
Ajiboye 2009 0.07 (0.03, 0.18) 4.65
Duclos 1998 0.02 (0.01, 0.08) 6.15
Gaete 2014 0.02 (0.01, 0.04) 6.59
Gretton 2011 0.02 (0.00, 0.06) 6.39
Harrington 2005 0.09 (0.05, 0.16) 5.21
Indig 2009 0.17 (0.13, 0.22) 5.63
Karnik 2009 0.08 (0.06, 0.10) 6.45
Lader A 1997 0.04 (0.02, 0.07) 6.43
Lader B 1997 0.04 (0.02, 0.08) 6.22
Lennox 2013 0.04 (0.02, 0.07) 6.32
Plattner 2007 0.24 (0.19, 0.30) 5.44
Ruchkin 2003 0.23 (0.19, 0.28) 5.75
Steiner 1997 0.32 (0.23, 0.42) 3.61
Teplin 2002 0.11 (0.09, 0.13) 6.51
Van Damme 2004 0.02 (0.01, 0.05) 6.52
Zhou 2012 0.02 (0.01, 0.04) 6.54
Subtotal (I^2 = 94.70%, p = 0.00) 0.09 (0.06, 0.12) 100.00
Females
Ariga 2008 0.32 (0.22, 0.44) 9.58
Caufmann 1998 0.49 (0.39, 0.59) 10.02
Dixon 2004 0.20 (0.13, 0.29) 10.64
Abrantes 2005 0.35 (0.21, 0.52) 8.11
Indig 2009 0.39 (0.25, 0.54) 8.35
Lader B 1997 0.07 (0.03, 0.15) 11.18
Karnik 2009 0.13 (0.08, 0.20) 11.18
Teplin 2002 0.15 (0.12, 0.18) 11.64
Plattner 2007 0.57 (0.43, 0.69) 8.97
Gretton 2011 0.13 (0.06, 0.24) 10.32
Subtotal (I^2 = 91.85%, p = 0.00) 0.27 (0.18, 0.35) 100.00
Heterogeneity between groups: p = 0.000
Overall (I^2 = 95.22%, p = 0.00); 0.14 (0.11, 0.17) .
0
.2
.4
.6
Prevalence Proportion

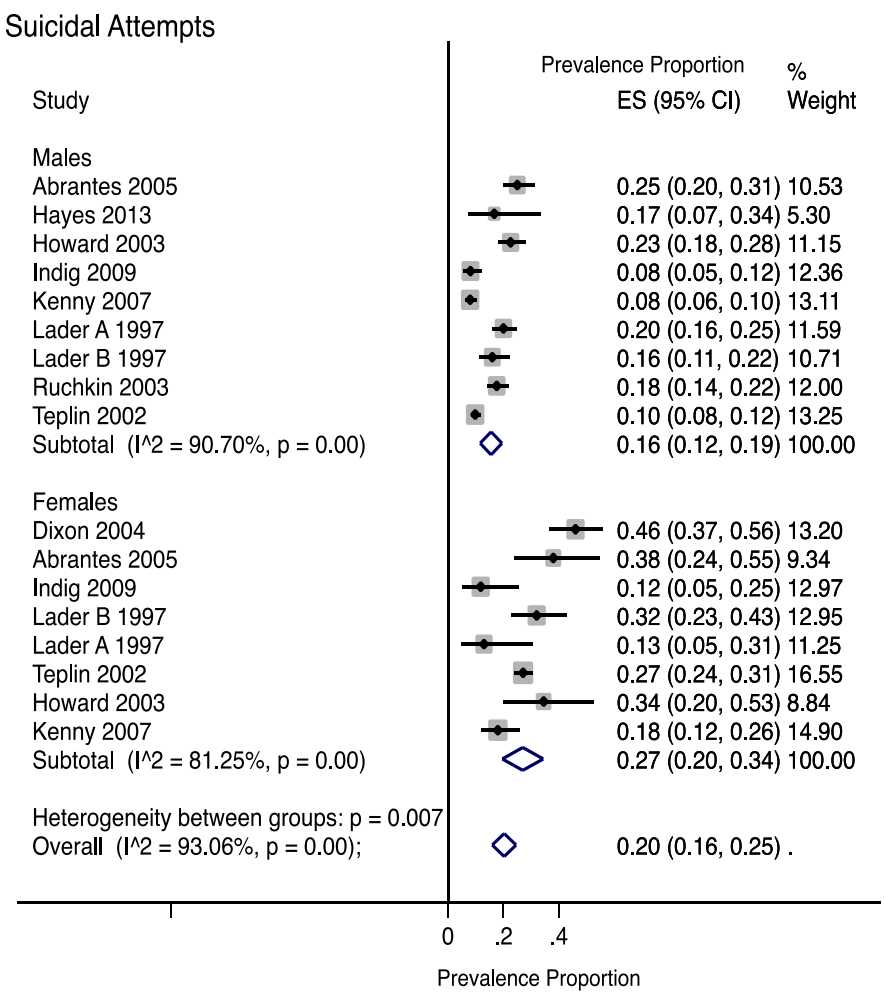

GAD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Gaete 2014 0.05 (0.03, 0.07) 12.71
Gretton 2011 0.02 (0.00, 0.06) 12.04
Harrington 2005 0.17 (0.11, 0.26) 4.67
Hayes 2013 0.10 (0.04, 0.26) 2.68
Indig 2009 0.07 (0.04, 0.10) 10.67
Karnik 2009 0.03 (0.02, 0.05) 13.58
Lader A 1997 0.05 (0.03, 0.08) 11.87
Lader B 1997 0.07 (0.04, 0.12) 9.30
Plattner 2007 0.12 (0.09, 0.17) 9.10
Teplin 2002 0.07 (0.06, 0.09) 13.37
Subtotal (I^2 = 82.33%, p = 0.00) 0.06 (0.04, 0.08) 100.00
Females
Ariga 2008 0.03 (0.01, 0.11) 12.36
Dixon 2004 0.05 (0.02, 0.11) 12.34
Indig 2009 0.10 (0.04, 0.24) 7.88
Lader B 1997 0.02 (0.00, 0.08) 13.26
Van Damme 2004 0.25 (0.20, 0.32) 10.77
Karnik 2009 0.05 (0.02, 0.10) 12.86
Teplin 2002 0.07 (0.06, 0.10) 13.88
Plattner 2007 0.26 (0.16, 0.40) 6.32
Duclos 1998 0.08 (0.03, 0.17) 10.34
Subtotal (I^2 = 86.67%, p = 0.00) 0.09 (0.05, 0.13) 100.00
Heterogeneity between groups: p = 0.257
Overall (I^2 = 84.32%, p = 0.00); 0.07 (0.05, 0.09) .
0
.2
.4
Prevalence Proportion

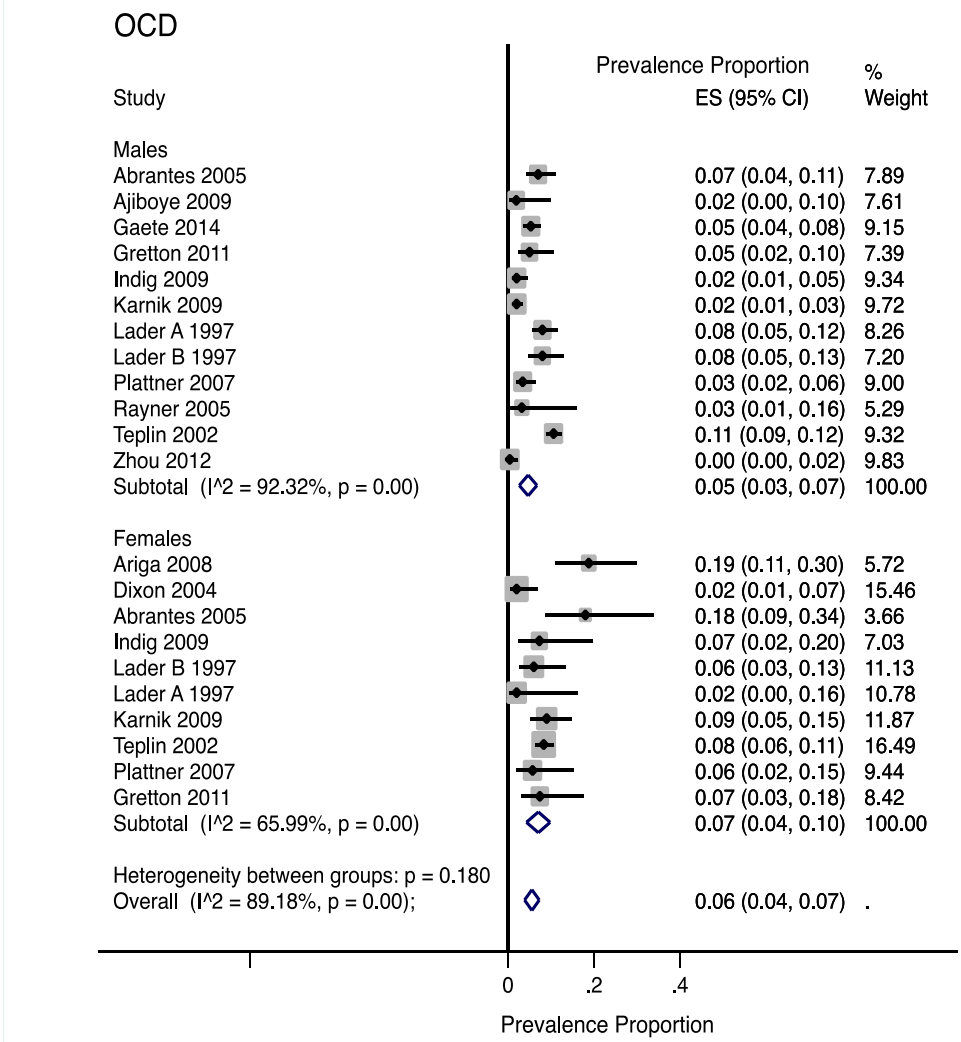

SAD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Ajiboye 2009 0.02 (0.00, 0.10) 12.05
Gaete 2014 0.04 (0.03, 0.06) 13.68
Hayes 2013 0.20 (0.10, 0.37) 3.80
Karnik 2009 0.12 (0.10, 0.15) 13.14
Plattner 2007 0.14 (0.10, 0.19) 11.56
Rayner 2005 0.07 (0.02, 0.21) 7.09
Runchkin 2003 0.09 (0.07, 0.13) 12.75
Teplin 2002 0.13 (0.11, 0.15) 13.57
Van Damme 2004 0.08 (0.05, 0.12) 12.37
Subtotal (I^2 = 89.39%, p = 0.00) 0.09 (0.06, 0.12) 100.00
Females
Ariga 2008 0.27 (0.17, 0.39) 19.12
Dixon 2004 0.01 (0.00, 0.05) 21.41
Karnik 2009 0.37 (0.29, 0.45) 20.13
Plattner 2007 0.49 (0.36, 0.62) 18.04
Teplin 2002 0.19 (0.16, 0.22) 21.30
Subtotal (I^2 = 97.95%, p = 0.00) 0.26 (0.11, 0.40) 100.00
Heterogeneity between groups: p = 0.027
Overall (I^2 = 95.20%, p = 0.00); 0.14 (0.10, 0.18).
0
.2
.4
.6
Prevalence Proportion

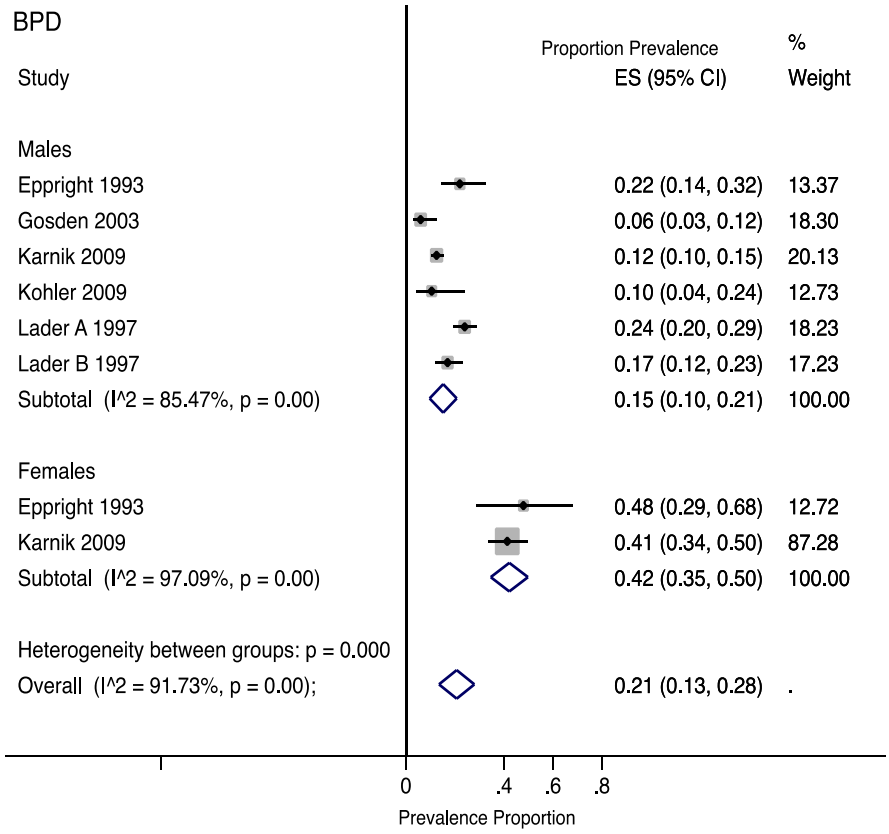

Phobia
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Gaete 2014 0.03 (0.02, 0.05) 27.85
Gosden 2003 0.04 (0.02, 0.10) 7.32
Gretton 2011 0.04 (0.02, 0.09) 8.98
Hayes 2013 0.07 (0.02, 0.21) 1.48
Indig 2009 0.03 (0.02, 0.06) 18.76
Lader A 1997 0.08 (0.05, 0.12) 11.23
Lader B 1997 0.05 (0.03, 0.09) 9.63
Plattner 2007 0.06 (0.03, 0.09) 12.70
Rayner 2005 0.05 (0.01, 0.19) 2.03
Subtotal (I^2 = 16.50%, p = 0.30) 0.04 (0.03, 0.06) 100.00
Females
Ariga 2008 0.19 (0.12, 0.31) 14.04
Dixon 2004 0.03 (0.01, 0.08) 22.58
Lader B 1997 0.10 (0.05, 0.18) 18.23
Lader A 1997 0.05 (0.01, 0.21) 15.73
Plattner 2007 0.13 (0.07, 0.25) 14.78
Gretton 2011 0.14 (0.07, 0.26) 14.64
Subtotal (I^2 = 73.89%, p = 0.00) 0.10 (0.04, 0.16) 100.00
Heterogeneity between groups: p = 0.064
Overall (I^2 = 54.36%, p = 0.01); 0.05 (0.04, 0.07).
0
.3
Prevalence Proportion

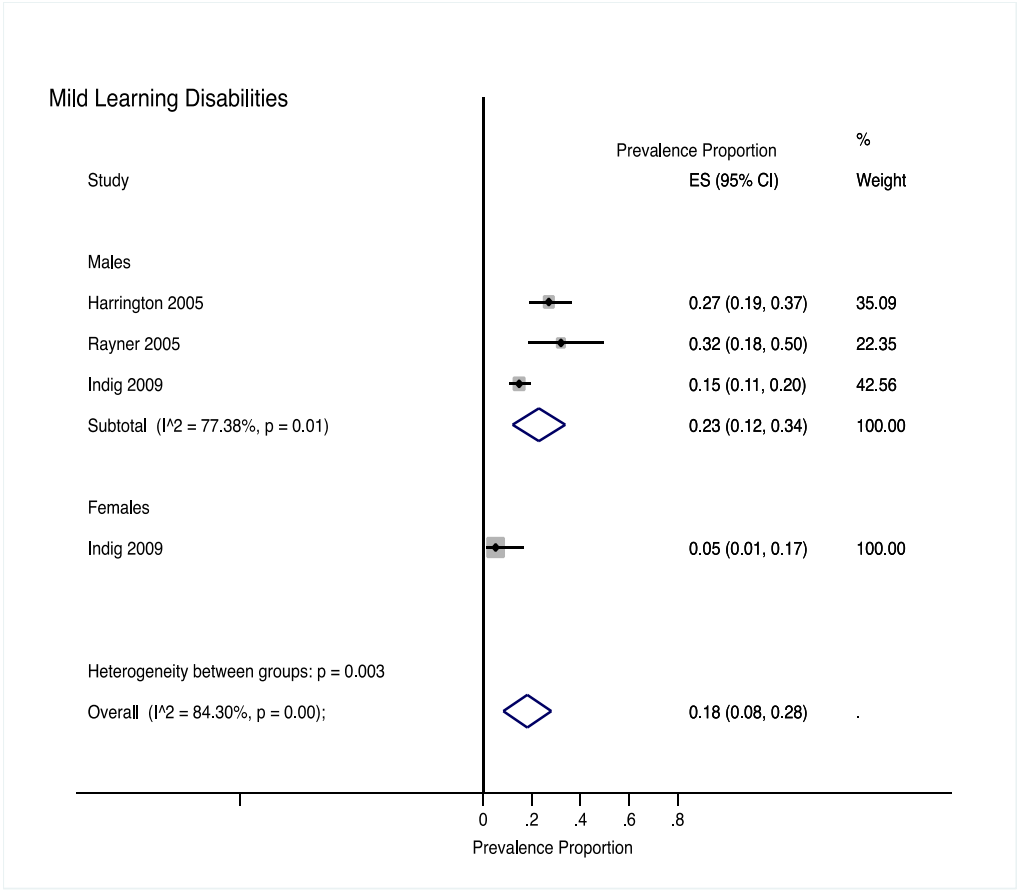

Panic Disorder
Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Abrantes 2005 0.09 (0.06, 0.14) 7.23
Ajiboye 2009 0.06 (0.02, 0.15) 3.78
Gaete 2014 0.05 (0.03, 0.07) 11.96
Gretton 2011 0.06 (0.03, 0.12) 6.49
Hayes 2013 0.03 (0.01, 0.17) 3.65
Karnik 2009 0.01 (0.00, 0.02) 14.91
Lader A 1997 0.04 (0.02, 0.07) 11.33
Lader B 1997 0.02 (0.01, 0.05) 11.50
Plattner 2007 0.03 (0.01, 0.05) 12.07
Rayner 2005 0.10 (0.03, 0.25) 1.61
Teplin 2002 0.00 (0.00, 0.01) 15.49
Subtotal (I^2 = 85.83%, p = 0.00) 0.03 (0.02, 0.05) 100.00
Females
Abrantes 2005 0.18 (0.09, 0.34) 6.22
Ariga 2008 0.17 (0.10, 0.28) 9.67
Dixon 2004 0.09 (0.05, 0.16) 15.32
Gretton 2011 0.06 (0.02, 0.15) 14.37
Karnik 2009 0.01 (0.00, 0.04) 22.24
Lader B 1997 0.01 (0.00, 0.06) 21.57
Plattner 2007 0.11 (0.05, 0.23) 10.60
Subtotal (I^2 = 80.18%, p = 0.00) 0.07 (0.03, 0.10) 100.00
Heterogeneity between groups: p = 0.109
Overall (I^2 = 84.00%, p = 0.00); 0.04 (0.02, 0.05) .
0
.2
Prevalence Proportion

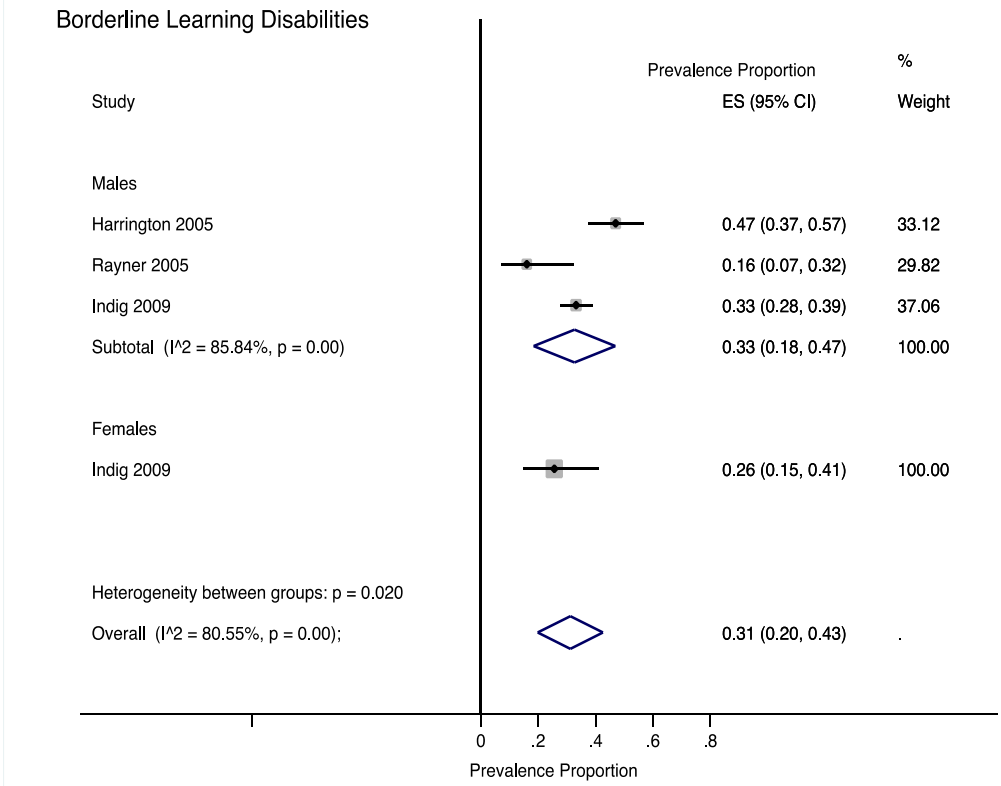

Self-harm
Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Indig 2009
0.14 (0.10, 0.18)
23.28
Kenny 2007
0.15 (0.13, 0.18)
27.02
Lader A 1997
0.07 (0.05, 0.10)
26.70
Lader B 1997
0.09 (0.06, 0.14)
22.99
Subtotal (I^2 = 83.68%, p = 0.00)
0.11 (0.07, 0.15)
100.00
Females
Indig 2009
0.35 (0.22, 0.51)
20.92
Lader B 1997
0.11 (0.06, 0.20)
26.56
Lader A 1997
0.03 (0.00, 0.18)
26.70
Kenny 2007
0.28 (0.21, 0.37)
25.81
Subtotal (I^2 = 90.19%, p = 0.00)
0.18 (0.05, 0.32)
100.00
Heterogeneity between groups: p = 0.314
Overall (I^2 = 86.09%, p = 0.00);
0.13 (0.09, 0.18)
.
0
.2
.4
Prevalence Proportion

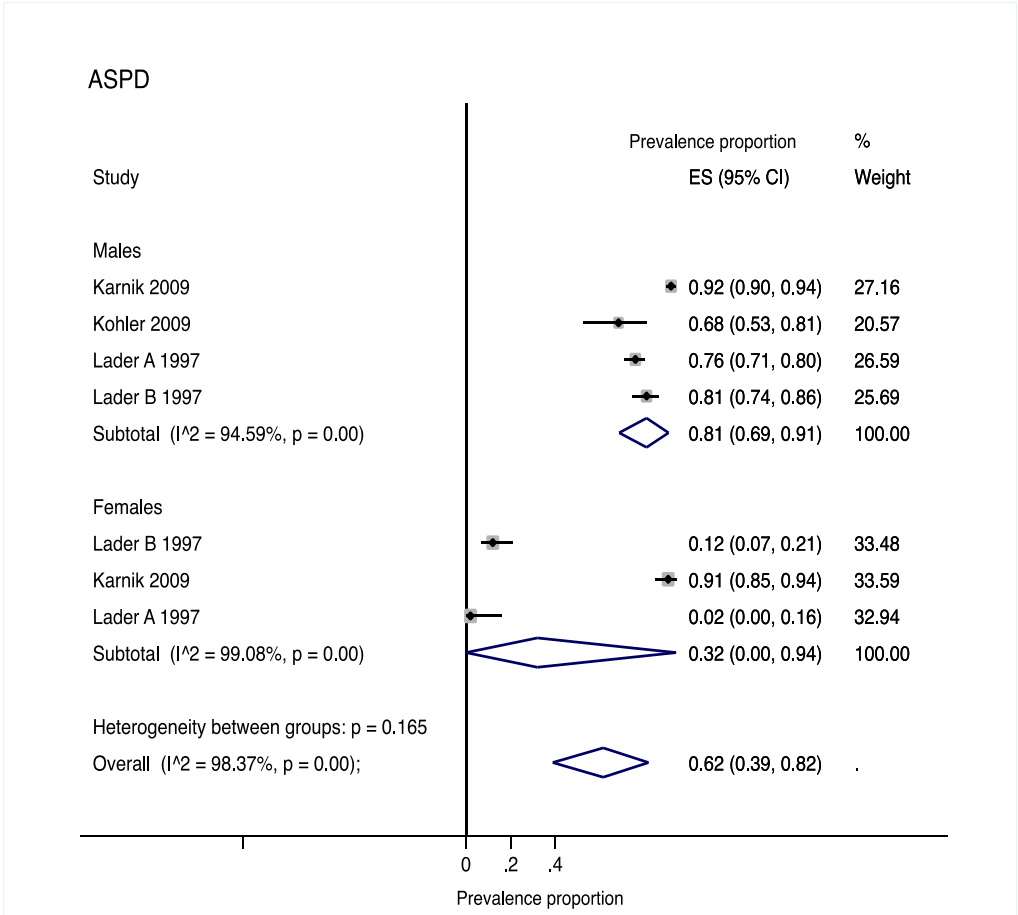

Suicidal Attempts
Prevalence Proportion
%
Study
ES (95% CI)
Weight
Males
Abrantes 2005 0.25 (0.20, 0.31) 10.53
Hayes 2013 0.17 (0.07, 0.34) 5.30
Howard 2003 0.23 (0.18, 0.28) 11.15
Indig 2009 0.08 (0.05, 0.12) 12.36
Kenny 2007 0.08 (0.06, 0.10) 13.11
Lader A 1997 0.20 (0.16, 0.25) 11.59
Lader B 1997 0.16 (0.11, 0.22) 10.71
Ruchkin 2003 0.18 (0.14, 0.22) 12.00
Teplin 2002 0.10 (0.08, 0.12) 13.25
Subtotal (I^2 = 90.70%, p = 0.00) 0.16 (0.12, 0.19) 100.00
Females
Dixon 2004 0.46 (0.37, 0.56) 13.20
Abrantes 2005 0.38 (0.24, 0.55) 9.34
Indig 2009 0.12 (0.05, 0.25) 12.97
Lader B 1997 0.32 (0.23, 0.43) 12.95
Lader A 1997 0.13 (0.05, 0.31) 11.25
Teplin 2002 0.27 (0.24, 0.31) 16.55
Howard 2003 0.34 (0.20, 0.53) 8.84
Kenny 2007 0.18 (0.12, 0.26) 14.90
Subtotal (I^2 = 81.25%, p = 0.00) 0.27 (0.20, 0.34) 100.00
Heterogeneity between groups: p = 0.007
Overall (I^2 = 93.06%, p = 0.00); 0.20 (0.16, 0.25) .
0
.2
.4
Prevalence Proportion

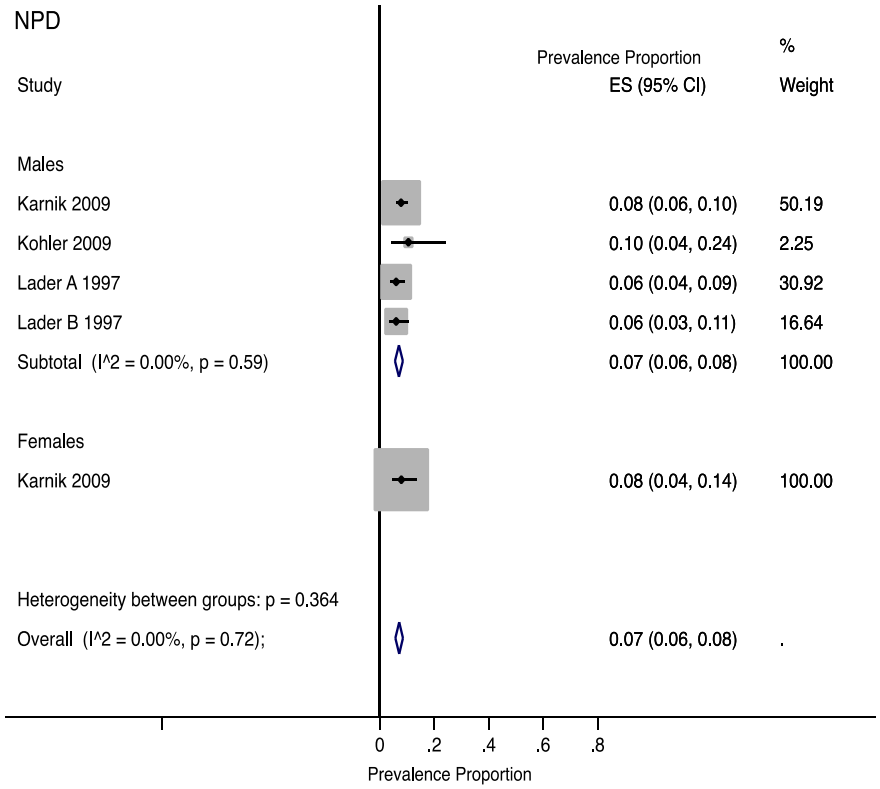

OCD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Abrantes 2005 0.07 (0.04, 0.11) 7.89
Ajiboye 2009 0.02 (0.00, 0.10) 7.61
Gaete 2014 0.05 (0.04, 0.08) 9.15
Gretton 2011 0.05 (0.02, 0.10) 7.39
Indig 2009 0.02 (0.01, 0.05) 9.34
Karnik 2009 0.02 (0.01, 0.03) 9.72
Lader A 1997 0.08 (0.05, 0.12) 8.26
Lader B 1997 0.08 (0.05, 0.13) 7.20
Plattner 2007 0.03 (0.02, 0.06) 9.00
Rayner 2005 0.03 (0.01, 0.16) 5.29
Teplin 2002 0.11 (0.09, 0.12) 9.32
Zhou 2012 0.00 (0.00, 0.02) 9.83
Subtotal (I^2 = 92.32%, p = 0.00) 0.05 (0.03, 0.07) 100.00
Females
Ariga 2008 0.19 (0.11, 0.30) 5.72
Dixon 2004 0.02 (0.01, 0.07) 15.46
Abrantes 2005 0.18 (0.09, 0.34) 3.66
Indig 2009 0.07 (0.02, 0.20) 7.03
Lader B 1997 0.06 (0.03, 0.13) 11.13
Lader A 1997 0.02 (0.00, 0.16) 10.78
Karnik 2009 0.09 (0.05, 0.15) 11.87
Teplin 2002 0.08 (0.06, 0.11) 16.49
Plattner 2007 0.06 (0.02, 0.15) 9.44
Gretton 2011 0.07 (0.03, 0.18) 8.42
Subtotal (I^2 = 65.99%, p = 0.00) 0.07 (0.04, 0.10) 100.00
Heterogeneity between groups: p = 0.180
Overall (I^2 = 89.18%, p = 0.00); 0.06 (0.04, 0.07) .
0
.2
.4
Prevalence Proportion

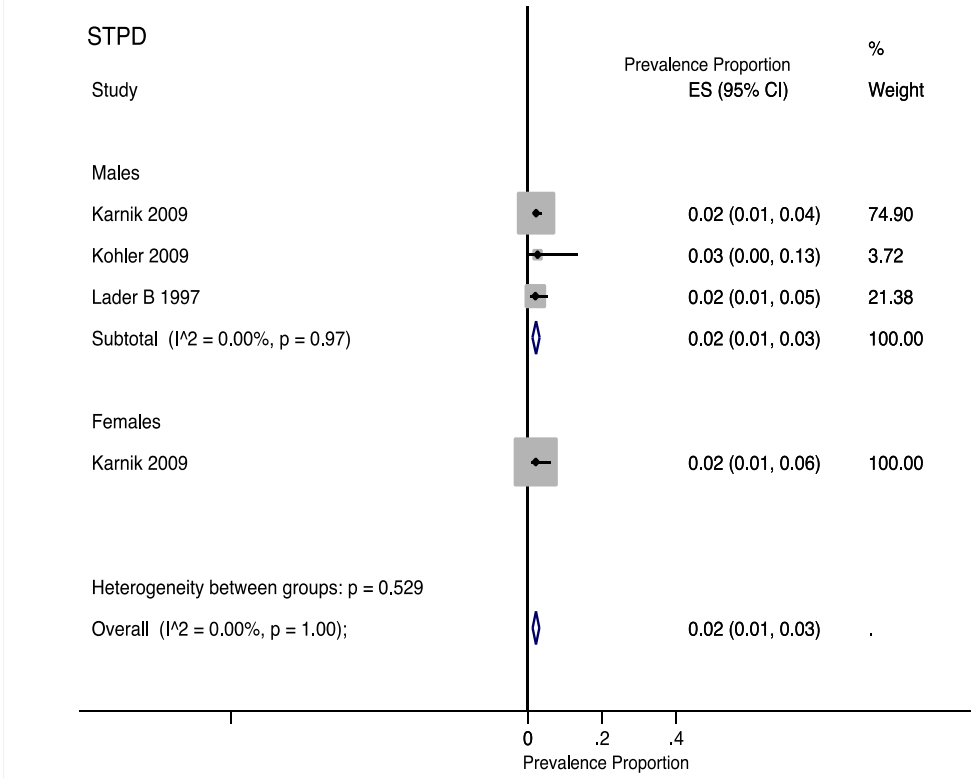

BPD
Study
Proportion Prevalence
ES (95% CI)
%
Weight
Males
Eppright 1993
0.22 (0.14, 0.32)
13.37
Gosden 2003
0.06 (0.03, 0.12)
18.30
Karnik 2009
0.12 (0.10, 0.15)
20.13
Kohler 2009
0.10 (0.04, 0.24)
12.73
Lader A 1997
0.24 (0.20, 0.29)
18.23
Lader B 1997
0.17 (0.12, 0.23)
17.23
Subtotal (I^2 = 85.47%, p = 0.00)
0.15 (0.10, 0.21)
100.00
Females
Eppright 1993
0.48 (0.29, 0.68)
12.72
Karnik 2009
0.41 (0.34, 0.50)
87.28
Subtotal (I^2 = 97.09%, p = 0.00)
0.42 (0.35, 0.50)
100.00
Heterogeneity between groups: p = 0.000
Overall (I^2 = 91.73%, p = 0.00);
0.21 (0.13, 0.28)
.
0
.4
.6
.8
Prevalence Proportion

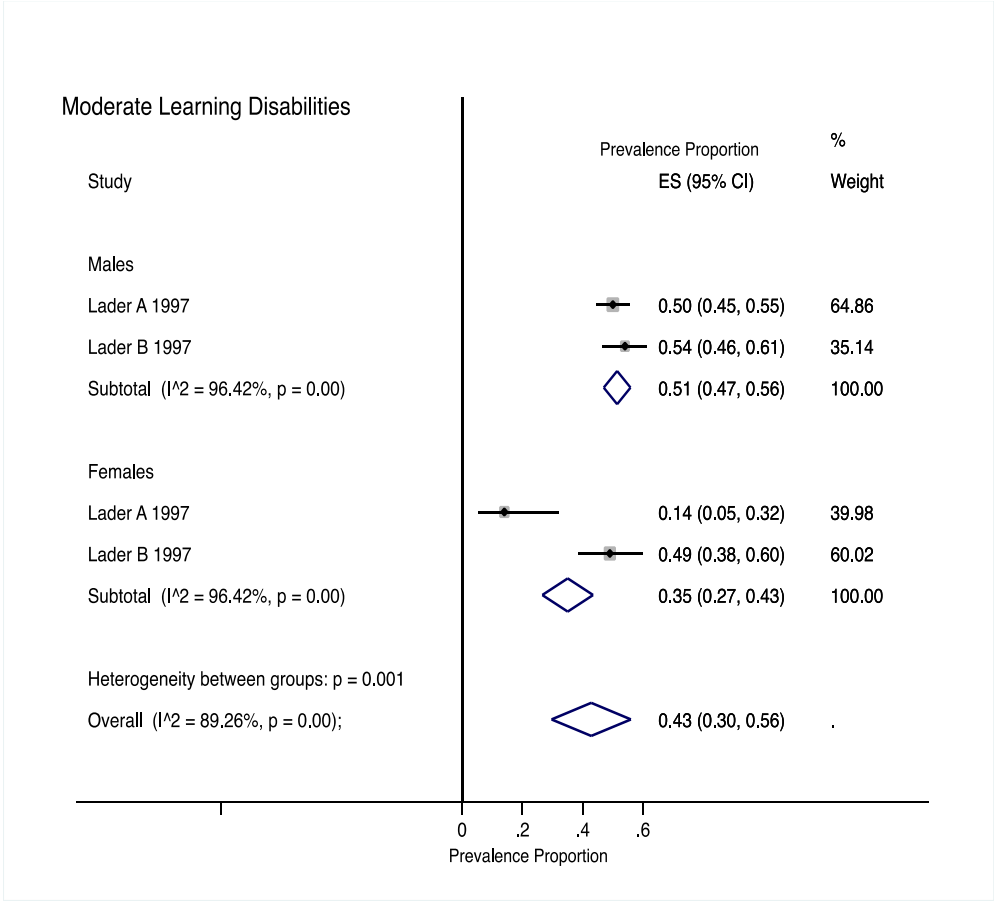

Mild Learning Disabilities
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Harrington 2005
0.27 (0.19, 0.37)
35.09
Rayner 2005
0.32 (0.18, 0.50)
22.35
Indig 2009
0.15 (0.11, 0.20)
42.56
Subtotal (I^2 = 77.38%, p = 0.01)
0.23 (0.12, 0.34)
100.00
Females
Indig 2009
0.05 (0.01, 0.17)
100.00
Heterogeneity between groups: p = 0.003
Overall (I^2 = 84.30%, p = 0.00);
0.18 (0.08, 0.28)
.
0
.2
.4
.6
.8
Prevalence Proportion


Borderline Learning Disabilities
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Harrington 2005
0.47 (0.37, 0.57)
33.12
Rayner 2005
0.16 (0.07, 0.32)
29.82
Indig 2009
0.33 (0.28, 0.39)
37.06
Subtotal (I^2 = 85.84%, p = 0.00)
0.33 (0.18, 0.47)
100.00
Females
Indig 2009
0.26 (0.15, 0.41)
100.00
Heterogeneity between groups: p = 0.020
Overall (I^2 = 80.55%, p = 0.00);
0.31 (0.20, 0.43)
.
0
.2
.4
.6
.8
Prevalence Proportion


ASPD
Prevalence proportion
%
Study
ES (95% CI)
Weight
Males
Karnik 2009
0.92 (0.90, 0.94)
27.16
Kohler 2009
0.68 (0.53, 0.81)
20.57
Lader A 1997
0.76 (0.71, 0.80)
26.59
Lader B 1997
0.81 (0.74, 0.86)
25.69
Subtotal (I^2 = 94.59%, p = 0.00)
0.81 (0.69, 0.91)
100.00
Females
Lader B 1997
0.12 (0.07, 0.21)
33.48
Karnik 2009
0.91 (0.85, 0.94)
33.59
Lader A 1997
0.02 (0.00, 0.16)
32.94
Subtotal (I^2 = 99.08%, p = 0.00)
0.32 (0.00, 0.94)
100.00
Heterogeneity between groups: p = 0.165
Overall (I^2 = 98.37%, p = 0.00);
0.62 (0.39, 0.82)
.
0
.2
.4
Prevalence proportion


NPD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Karnik 2009
0.08 (0.06, 0.10)
50.19
Kohler 2009
0.10 (0.04, 0.24)
2.25
Lader A 1997
0.06 (0.04, 0.09)
30.92
Lader B 1997
0.06 (0.03, 0.11)
16.64
Subtotal (I^2 = 0.00%, p = 0.59)
0.07 (0.06, 0.08)
100.00
Females
Karnik 2009
0.08 (0.04, 0.14)
100.00
Heterogeneity between groups: p = 0.364
Overall (I^2 = 0.00%, p = 0.72);
0.07 (0.06, 0.08)
.
0
.2
.4
.6
.8
Prevalence Proportion


STPD
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Karnik 2009
0.02 (0.01, 0.04)
74.90
Kohler 2009
0.03 (0.00, 0.13)
3.72
Lader B 1997
0.02 (0.01, 0.05)
21.38
Subtotal (I^2 = 0.00%, p = 0.97)
0.02 (0.01, 0.03)
100.00
Females
Karnik 2009
0.02 (0.01, 0.06)
100.00
Heterogeneity between groups: p = 0.529
Overall (I^2 = 0.00%, p = 1.00);
0.02 (0.01, 0.03)
.
0
.2
.4
Prevalence Proportion


Moderate Learning Disabilities
Study
Prevalence Proportion
ES (95% CI)
%
Weight
Males
Lader A 1997
0.50 (0.45, 0.55)
64.86
Lader B 1997
0.54 (0.46, 0.61)
35.14
Subtotal (I^2 = 96.42%, p = 0.00)
0.51 (0.47, 0.56)
100.00
Females
Lader A 1997
0.14 (0.05, 0.32)
39.98
Lader B 1997
0.49 (0.38, 0.60)
60.02
Subtotal (I^2 = 96.42%, p = 0.00)
0.35 (0.27, 0.43)
100.00
Heterogeneity between groups: p = 0.001
Overall (I^2 = 89.26%, p = 0.00);
0.43 (0.30, 0.56)
.
0
.2
.4
.6
Prevalence Proportion

Appendix 5. HRA Approval

NHS
Health Research Authority

Professor Swaran Singh
MBBS, MD, MRCPsych
University of Warwick
Medical School Building
Gibbet Hill Campus
University of Warwick Coventry
CV4 7AL

Email: hra.approval@nhs.net

17 June 2016

Dear Professor Singh

Letter of HRA Approval for a study with an existing UK study wide review

Study title:	**Transition of care in young offenders with ongoing mental health problems across England**
IRAS project ID:	**192731**
Sponsor:	**Warwick University**

Thank you for your request to bring the above referenced study under HRA Approval.

I am pleased to confirm that the study has been given **HRA Approval.** This has been issued on the basis that a study wide review has previously been undertaken, which has confirmed that the study is compliant with the UK wide standards for research in the NHS.

The extension of HRA Approval to this study on this basis allows the sponsor and participating NHS organisations in England to set-up the study in accordance with HRA Approval processes, with decisions on study set-up being taken on the basis of capacity and capability alone.

If you have submitted an amendment to add a new site between 23 March 2016 and the date of this letter, the addition of the new site is also approved.

Participation of NHS Organisations in England

The sponsor should provide a copy of this letter, together with the local document package and a list of the documents provided, to participating NHS organisations in England that are being set up in accordance with HRA Approval Processes. It is for the sponsor to ensure that any documents provided to participating organisations are the current, approved documents.

For non-commercial studies the local document package should include an appropriate Statement of Activities and HRA Schedule of Events. The sponsor should also provide the template agreement to

Appendix 6. Sponsorship letter

Prof Swaran Singh
Mental Health &
Wellbeing Warwick
Medical School
University of Warwick
Coventry
CV4 7AL
United Kingdom

9th November 2015

Project Title: Transition of care in young offenders with ongoing mental health problems across England
Chief Investigator: Professor Swaran Singh
Our Ref: REGO-2015-1716

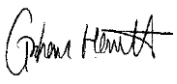
Dear Professor Singh,

I confirm that the University of Warwick will act as Research Sponsor for the above project, in accordance with the Department of Health's Research Governance Framework for Health and Social care (2005), and, where appropriate, UK Statutory Instrument Number 1031, that implements the Medicines for Human Use (Clinical Trials) Directive 2004 and subsequent amendments.

I confirm that the University holds Public and Products Liability Insurance, and, where appropriate, Clinical Trial Insurance, which will provide cover for this study.

Any researcher involved in the project is required at all times to comply with the University of Warwick's Research Code of Practice.

Best wishes



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Date: 09/11/2015

Appendix 7. Mapping exercise questionnaire

Mapping exercise-Service Evaluation Questionnaire

This study aims to explore the process of transition from forensic Child & Adolescent Mental Health Services (CAMHS) to adult mental health services across England. We specifically want to identify the organisational factors that facilitate or impede effective transition of patients from adolescent medium secure units to adult mental health services. We want to understand how services plan transition, how the process is implemented and what problems, if any, are perceived by those undergoing transition.

The study is funded by CLAHRC West Midlands in collaboration with the University of Warwick. No group or individual will be making any commercial or financial gain from it.

As an initial step, we are mapping current service provision. We would be very grateful if you could spend a few moments to fill the enclosed questionnaire.

All data will be treated in the strictest confidence. Your team will not be identified in any database and the data will not be used for any purpose other than the mapping exercise.

For the purpose of this study*, a service is defined as provider agency that provides CAMHS tier 4 services with shared transition protocols and procedures*. If within your service, some teams use different protocols or procedures for transition, please count each group of teams using a shared transition procedure/policy/protocol as a distinct service.

If you have any queries, comments or suggestions, please contact :
Maria Livanou Tel: 078 79056605, E-mail: M.I.Livanou@warwick.ac.uk
Prof. Swaran P Singh Tel: 024 76150190, E-mail: S.P.Singh@warwick.ac.uk
Dr Vivek Furtado Tel: 024 76574362, E-mail: V.Furtado@warwick.ac.uk

Many thanks for your help

Date _____ **Team ID Number** ____

Team name _____

Respondent _____

Name: _____

Profession: _____

Job Title: _____

Service type:

CAMHS Assertive Community Team Adolescent Service

Other specialist service (please specify) _____

Staffing levels: Total FTE equivalent (Full Time =1.0; for part time, each half day= 0.1)

Total mental health care staff (excluding trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing		
Psychology		
Psychiatry		
Social work		
Systemic Psychotherapy/ Family Therapy		
Psychodynamic Psychotherapy		
Experiential Psychotherapy, e.g. Art Therapy		
Child Primary Mental Health Practitioner		
Occupational Therapy		
Other (please specify)		
Other (please specify)		

Case load: What is your team's caseload?

A case is defined as 'a young person with whom your service has been actively working. Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion. The length of time spent with a case is not important.

Numbers referred in the last calendar year _____

Number of currently open cases _____

(The last calendar year will be taken as June 1st – May 31st 2016)

Adult teams: How many adult teams does your service relate to and/or transfer cases to?

CMHTs ____ Eating Disorders ____

Learning Disability ____ Psychotherapy ____

Forensic Services ____

Others (please specify) _____

Transition boundary: How do you define the boundary between your service and adult services (that is, the criteria for referral on to the adult service)?

Age limit _____ Educational status _____

Other _____

Please give details:

……
……..

Transition numbers: How many patients stay within the service after crossing the transition boundary?

Please state the average number per year over the last three years _____

Closure policy: Do you have a written Closure policy?

Yes No

If yes, please attach a copy.

Transition protocol: Do you have a written policy/guidelines for transition of patients under your care to adult services?

Yes No

If yes, please attach a copy.

Transition management: Do you have a written policy/guideline for managing the interface (i.e. the point at which interaction occurs) between your service and adult services (incl. guidelines for discharge)?

Yes No

If yes, please attach a copy.

Potential referrals: How many cases on average do you consider to be suitable for transfer to adult services?

Please state the average number per year over the last three years _____

Referrals accepted: How many cases on average make a transition from your service to adult services?

Please state the average number per year over the last three years _____

Transition Process: for patients making a transition, do you aim for?

(a) Documented handover planning

Always	
Sometimes	
Never	

(b) Joint meeting with adult service

Always	
Sometimes	
Never	

(c) Involvement of the parents/carer in care plan and decision-making

Always	
Sometimes	
Never	

(d) Involvement of the service users in care plan and decision-making

Always	
Sometimes	
Never	

(e) Preparing the young person for ending one therapeutic relationship and starting another

Always	
Sometimes	
Never	

(f) Accountability for the process (e.g. a single clinician may be identified from one of the services to co- ordinate the transition).

Always	
Sometimes	
Never	

Please elaborate on how you carry out the above, and on how you carry out any other aspects of the transition process:
(Please continue on a separate sheet if necessary)

On the next page, please provide us with details of all patients who are about to cross your transition boundary in the next 6 months and will or could be transferred by your service to adult services. The information obtained in this study will be entirely confidential. It will be stored on a computer with each service identified only by a number code. Only the researchers involved in the study will be able to view the information. The mapping report will not identify services and not be circulated. However, it will appear in print at some stage.

Many thanks for your help.

Patient list for May 30th 2016- November 30th 2016

Young people referred (name of the young person optional).

DOB	Gender	Ethnicity	Diagnosis	Offence	Mental Health Act	Adult service referred to

Appendix 8. Staffing levels from mapping exercise

Hospital 1.

Total mental health care staff (including trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing Band 3 Band 5 Band 6 Band 7 Band 8a Band 8b	 30 18 6 2 .33 .33	
Psychology	2	
Psychiatry 2 consultants 2 trainees	2 2	2
Social work	1.8	
Systemic Psychotherapy/ Family Therapy	0.7	
Psychodynamic Psychotherapy	0	
Experiential Psychotherapy, e.g. Art Therapy	0	
Child Primary Mental Health Practitioner	0	
Occupational Therapy Activity workers unqualified	2 3	

Hospital 2.

Total mental health care staff (including trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing	About 90- including band 8,7, 6, 5 , 3 and 2	
Psychology	2 plus assistant psychologist	1
Psychiatry	2 staff grades plus 2.6 consultants	2.6
Social work	1	
Systemic Psychotherapy/ Family Therapy	1.5 family therapists	
Psychodynamic Psychotherapy	0	
Experiential Psychotherapy, e.g. Art Therapy	O.8	
Child Primary Mental Health Practitioner	0	
Occupational Therapy	4	
Other (please specify)SALT	0.2	

Hospital 3.

Total mental health care staff (including trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing	13	0
Psychology (trainees as well)	1.3	0.5
Psychiatry (no junior-trainee doctor)	1.25	1.25
Social work	1	0
Systemic Psychotherapy/ Family Therapy	0	0
Psychodynamic Psychotherapy	0	0
Experiential Psychotherapy, e.g. Art Therapy YESMUSIC THERAPIST	0.6	0
Child Primary Mental Health Practitioner	0	0
Occupational Therapy	0.6	0
Other (please specify) Healthcare support workers	18	0

Hospital 4.

Total mental health care staff (including trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing	11	1.0
Psychology	1.0	
Psychiatry	1.0	1.0
Social work	0.5	
Systemic Psychotherapy/ Family Therapy	1.0	
Psychodynamic Psychotherapy	0	
Experiential Psychotherapy, e.g. Art Therapy	2.5	
Child Primary Mental Health Practitioner	0	
Occupational Therapy	0	
Other (please specify) education	3 teachers	1 Head Teacher

Hospital 5.

Total mental health care staff (including trainees)		

	Total FTE per discipline	Total FTE at Consultant grade
Nursing	12.0	
Psychology	6	2.
Psychiatry	3	2.
Social work	1.5	
Systemic Psychotherapy/ Family Therapy	02.	
Psychodynamic Psychotherapy	0	
Experiential Psychotherapy, e.g. Art Therapy	0	
Child Primary Mental Health Practitioner	0	
Occupational Therapy	2	
Other (please specify)	S&LT	
Other (please specify)	Activity workers 2	
Other (please specify)	Exercise therapist=1	

Hospital 6.

Total mental health care staff (including trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing		
Psychology	1.5	1.0
Psychiatry	2.0	2.0
Social work		0.5
Systemic Psychotherapy/ Family Therapy	0	0
Psychodynamic Psychotherapy	0	0
Experiential Psychotherapy, e.g. Art Therapy	0	0
Child Primary Mental Health Practitioner		
Occupational Therapy	2.0	
S&L		
Physiotherapy		
Other (please specify)		

Appendix 9. Case note review forms/proforma

Stage 2

Case Note Review – Transition from CAMHS to Adult MHS

Actual Referrals

Case no:

Patient name:

Case note reviewer: _____

Date of data collection:_____

This questionnaire should be completed only if the young person was successfully transferred to adult services.

When completing:

- **in general, tick boxes**
- **NR=not recorded**

SECTION 1: SERVICE / TRANSITION DETAILS

(must be completed prior to completing rest of the form)

CAMHS Team name and locality: _____

Team Borough or National/Specialist: _____ Trust: _____

Transitional hierarchy for completion of case note review:
Young person referred to AMHS (whether referral accepted or not): Yes □□ No □□

o if **yes**, data in Section 2 relates to time that referral was made

if **no**, data in section 2 relates to time of crossing CAMHS/AMHS boundary (whether young person still being seen by CAMHS or not). In this case, **for this CAMHS**, please specify criteria for crossing **CAMHS/AMHS boundary:**

□□ age (specify:_____),

□□ leaving full-time education (specify: secondary school/ 6th form/college), OR

□□ other boundary (specify:_____)

Information collected from:

CAMHS notes □□ CAMHS electronic records □□ AMHS notes □□

AMHS electronic records □□ Other □□ (specify)_____

SECTION 2: DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

YOUNG PERSON:

Date of birth: _____ (date) _____(month)_____(year) Gender: Male / Female

Address: _____

_____

_____ UR/PID (NHS Patient Identification Number): _____

Ethnic Group [Insert no., see appendix 1]: ____ NR □□

First Language: English □□ Other □□ (please state _____) NR □□Second language: English □□ Other □□ (please state _____) NR □□Age: _____

- **If the young person is under 18**:

o name of identified person with parental responsibility:

address: _____

_____

tel. no.: _____

o A Looked After Child? Yes □□ No □□

- **If the young person is over 18 years:**

o Does he/she have an identified carer? Yes □□ No □□

o Relationship to young person: Parent □□ Sibling □□ Extended family member □□

Partner (or girlfriend/boyfriend) □□ Friend □□ Other □□ (please state _____)

Young person's living arrangements:

On own □□ parental home □□ mother's home □□ father's home □□ foster carer's home □□

shared accommodation (not with family) □□ in another's home (describe relationship) □□

Are other agencies involved with the young person? □□ health (please state _____) □□ social care (please state _____) □□ education (please state _____) □□ voluntary (please state _____)

□□ criminal justice system (please state _____)

Is the young person in education?
Full time □□ Part time □□ No □□ NR □□

If so: School □□ college □□ other □□ (specify:_____)

What is the highest level of education reached to date? Some School □□ GCSE □□ Some college □□ A-level □□Other □□ (specify:_____) NR □□

Is the young person currently in employment?

Full time □□ Part time □□ No □□ NR □□

If so, specify type: _____

FAMILY DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

Parents' details:

Married & cohabiting □□ Cohabiting □□ Separated □□ Divorced □□ NR □□

If parents separated or divorced or looked after child (specify which or both): _____ Current contact with mother: regular □□ irregular □□ none □□

Current contact with father: regular □□ irregular □□ none □□

Parental Occupation: Father _____ / NR □□

Mother _____ / NR □□

Family history of mental health difficulties:

Overall:	Yes □□	No □□	NR □□
Mum	Yes □□	No □□	NR □□
Dad	Yes □□	No □□	NR □□
Siblings	Yes □□	No □□	NR □□
Uncles/aunts	Yes □□	No □□	NR □□
Grandparents	Yes □□	No □□	NR □□
Other family	Yes □□	No □□	NR □□

Family members who attend CAMHS

Mother: regularly □□ sometimes □□ never □□

Father: regularly □□ sometimes □□ never □□

One or more siblings: regularly □□ sometimes □□ never □□

Other family member(s):

please specify _____: regularly □□ sometimes □□ never □□

please specify _____: regularly □□ sometimes □□ never □□

please specify _____: regularly □□ sometimes □□ never □□

SECTION 3: DETAILS OF REFERRAL TO CAMHS FOR THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

Has a carer's assessment been offered at any stage?

If so, by whom? CAMHS □□ Adult MHS □□ Other □□ (specify _____) If so, when? Be

Referral: Routine □□ Urgent □□

Referred by: prison psychiatrist □□ TIER 3 CAMHS □□ YOT □□ NHS responsible psychiatrist □□ YOI □□ STC □□ local authorities' secure children's homes □□ adult units □□ open or low secure adolescent unit □□ Other □□ (specify _____)

Reasons for referral? (tick as many as are relevant) Emotional (e.g. anxiety, depression, OCD) □□ Behavioural □□
Developmental (e.g. autism spectrum disorder, ADHD) □□ Eating Disorder □□ Psychosis □□Family relationship issues □□ Crisis or complex psychosocial (e.g. deliberate self harm) □□Learning difficulties □□ Poor academic progress □□ peer problems □□
Other □□ (specify _____)

SECTION 4: DETAILS OF ASSESSMENT AT CAMHS DURING THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

How many weeks between referral and assessment? _____

Assessed by (specify number of each profession in brackets):

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( ) Social Worker ( )
Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( ) Experiential Therapist (e.g. Art, Drama. Specify:_____) ( ) Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Initial Diagnoses (from correspondence to referrer/case notes): Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____ DSM 4 code diagnoses: _____ code: _____ Other: _____

Previous contact with this CAMHS / another CAMHS

specify number _____ nil □ NR □ Age at first referral to any CAMHS _____ Number of other CAMHS attended _____ Age at first referral to this CAMHS _____

Number of previous (not including this referral) referrals to this CAMHS _____ Number of previous referrals to this CAMHS not accepted by service _____ Cumulative length of episodes of care, prior to this episode, at this CAMHS _____

List all known diagnoses / key problems for all previous contact with any CAMHS:

SECTION 5: DETAILS OF SUBSEQUENT CONTACT WITH THIS CAMHS

Interventions delivered (tick as many as relevant)

Medication □ Family Therapy □ General support or follow up □

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) □

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) □

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) □

Consultation / liaison with other agencies □

If so: SchoolEducation □ Social Services □ YOT (Youth Offending Service) □

Multi-agency □ Other (specify _____) □

Other (specify: _____) □

CAMHS professionals who delivered face-to-face work or consultation:

Total number: _____

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( ) Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( ) Experiential Therapist (e.g. Art, Drama. Specify:_____) ( ) Paediatrician ( ) Paediatric Nurse ( )

Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s): _____

Status: While attending CAMHS, was the young person, at any time:

- A Looked After Child (in Care) / attending Leaving Care services

  Yes □□ No □□ NR □□

- Given a Statement of Special Educational Needs: Yes □□ No □□ NR □□
- On the Child Protection Register: Yes □□ No □□ NR □□

o If yes, specify categories:

physical abuse □□ emotional abuse □□ sexual abuse □□ neglect □□

- Admitted to hospital for mental health problems: Yes □□ No □□ NR □□

□□ mental health unit

□□ paediatric unit

- Detained under a section of the Mental Health Act 1983

o Yes □□ No □□ NR □□

o If yes; Section 2 □□ Section 3 □□ other □□ (specify_____)

- Involved with YOT Yes □□ No □□ NR □□
- Refugee or asylum seeker Yes □□ No □□ NR □□

AT TIME OF REFERRAL TO AMHS / CROSSING TRANSITIONAL BOUNDARY

Number of weeks between assessment at CAMHS and referral to AMHS/ crossing transitional boundary: _____

CLINICAL DETAILS

Clinicians involved (specify number of each profession in brackets**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( ) Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( ) Experiential Therapist (e.g. Art, Drama. Specify:_____) ( ) Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s):_____

Diagnoses / Impression (from correspondence/case notes): Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____ DSM 4 code diagnoses: _____ code: _____ Other: _____

Interventions being delivered (tick as many as relevant)

Medication □□ Family Therapy □□ General support or follow up □□

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) □□

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) □□

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) □□

Consultation / liaison with other agencies □□

If so: Early Intervention in Psychosis Team (EIT) □□ other AMHS □□ School/Education □□

Social Services □□ Multi-agency □□ other □□ (specify _____) Other (specify: _____)

Status:

- A Looked After Child (in Care) / attending Leaving Care services

  Yes □□ No □□ NR □□
- Has a Statement of Special Educational Needs: Yes □□ No □□ NR □□
- On the Child Protection Register: Yes □□ No □□ NR □□

o If yes, specify categories:

physical abuse □□ emotional abuse □□ sexual abuse □□ neglect □□

- In a hospital for mental health problems: Yes □□ No □□ NR □□

□□ mental health unit

□□ paediatric unit

- Detained under a section of the Mental Health Act 1983

o Yes □□ No □□ NR □□

o If yes; Section 2 □□ Section 3 □□ other □□ (specify_____)

- Care Programme Approach (CPA)

o Yes □□ No □□ NR □□

o Standard □□ Enhanced □□

- Involved with YOT Yes □□ No □□ NR □□
- Refugee or asylum seeker Yes □□ No □□ NR □□

REFERRAL DETAILS

Method of successful referral: (tick as many as are relevant; this refers to the ultimately successful referral to adult services. Any initial unsuccessful referrals will be recorded later) Letter □□ telephone □□ electronic □□ other □□ (specify _____)

If letter, copied to: GP □□ young person □□ Parent(s)/carer(s) □□ Other □□ (specify _____)

Clinicians involved in successful referral:

Discipline of clinician making any referral to AMHS: _____

Referral was sent: Discipline of clinician, if specified _____ Specific AMHS: _____

Reason for referral: Presentation (tick as many as indicated)

on going mental health problems/disorders requiring specialist treatment: specify medication and/or psychological treatment and/ or monitoring _____

new episode of the mental health problem(s)/disorder(s) for which the young person was already seen by CAMHS

new episode of a different mental health problem(s)/disorder(s) in a young person who was already seen by CAMHS for a different problem/disorder

new episode of mental health problem(s)/disorder(s) in a young person newly referred to and assessed by CAMHS

new episode of mental health problem(s)/disorder(s) in a young person newly referred to but not assessed by CAMHS

□□ Management of risk (specify: self-harm or suicide □□ harm to others □□ self-neglect □□ vulnerability to abuse □□)

□□ other (specify: _____)

Detail in referral: (circle as many as indicated)

o Diagnoses or presentation: included □□ not included □□

o current treatment: included □□ not included □□

	past mental health history:	included □□	not included □□
o o	past medical history:	included □□	not included □□
o	family history:	included □□	not included □□
o o	family mental health history:	included □□	not included □□
o	current household:	included □□	not included □□
	current status:	included □□	not included □□

Successful Referral to:

Type of AMHS: CMHT □□ consultant psychiatrist □□ Psychology Team □□

adult inpatient unit □□ Early Intervention I Psychosis Team □□

Eating Disorders Service □□ Learning Disability Service □□ Forensic Service □□

Adult psychotherapy Service □□ Other □□ (specify_____)

Reason for choice of service: (tick as many as appropriate):

local service □□ type of assessment required □□ type of intervention required □□

type of disorder or condition □□ severity of disorder or condition □□ patient preference □□

parent or carer preference □□ other □□ (specify_____) Other

unavailable services that would have been referred to: _____

Number of weeks between referral being made and any response from AMHS: ____ Number of weeks

between referral being made and decision from AMHS: ____

Decision about referral made by AMHS:

o accepted and allocated □□ accepted to waiting list □□

o following discussion with CAMHS □□ without discussion □□

If not ultimately accepted by any CAMHS, fill in potential referral questionnaire instead of this one.

Details of any unsuccessful referrals:

Were any unsuccessful attempts at referring to AMHS made prior / concurrently to this referral?
Yes □□ No □□

If yes:o What was method of unsuccessful referral (tick as many as are relevant)?

Letter □□ telephone □□ electronic □□ other □□ (specify _____)

If letter, copied to: GP □□ young person □□ Parent(s)/carer(s) □□ Other □□ (_____)

o What discipline was the clinician who made the unsuccessful referral to AMHS?

_____

o To whom the unsuccessful referral was sent:

Discipline of clinician, if specified _____ Specific AMHS:

_____

o Type of AMHS: CMHT □□ consultant psychiatrist □□ Psychology Team □□

adult inpatient unit □□ Early Intervention I Psychosis Team □□

Eating Disorders Service □□ Learning Disability Service □□ Forensic Service □□

Adult psychotherapy Service □□ Other □□ (specify_____)

o Reason for choice of service: (tick as many as appropriate):

Local service □□ type of assessment required □□ type of intervention required □□

type of disorder or condition □□ severity of disorder or condition □□

patient preference □□ parent or carer preference □□ other □□ (specify_____)

o Non-acceptance of referral communicated: to CAMHS referrer □□ to young person □□

to parent(s)/carer(s) □□ to General Practitioner □□

o Reason: does not meet referral criteria □□

no relevant service available (specify what service: _____) □□

no relevant expertise (specify in what: _____) □□

No reason □□ other reason (specify _____) □□

o Alternative sources of help suggested: no □□ yes □□ (specify_____)

TRANSITION PROCESS Preparation of family:

Transfer of care mentioned to young person: Yes (date: _____) □□ No □□ NR □□

Transfer of care mentioned to parent(s)/carer(s): Yes (date: _____) □□ No □□ NR □□

Young person's consent for referral to AMHS sought:

documented clearly □□ inferred □□ not recorded □□

Reason for transfer to AMHS communicated to young person:

documented clearly □□ inferred □□ not recorded □□

Discussion about the ending of the therapeutic relationship(s):

documented clearly □□ inferred □□ not recorded □□

Preparation for professionals

Transition planning meeting between CAMHS and AMHS (number): (__) offered by CAMHS but not taken up by AMHS

(__) offered but not arranged

(__) offered and arranged

(__) discussion between professionals alongside joint appointment with young person

(__) discussion between professionals alongside joint appointment with parent(s)/carer(s) (__) discussion between professionals alongside joint appointment with young person and parent(s)/carer(s)

AMHS staff involved in transition planning meeting (identify* professionals the young person will see, if they are involved):

_____ Involved? Yes □□ No □□

_____ Involved? Yes □□ No □□

CAMHS staff involved in transition planning meeting (identify* professionals the young person has been seeing, if they are involved):

_____ Involved? Yes □□ No □□

_____ Involved? Yes □□ No □□

Contents (tick as many as necessary): timeframe □□ transition boundary □□

reasons for suggested referral to AMHS □□ information about AMHS □□

what will be initially offered by AMHS □□ who will initially see the young person □□

change from family-oriented service to individual-oriented service □□ Issues of consent □□concerns of young person □□ concerns of parent/carer(s) □□ preferences of young person □□preferences of parent(s)/carer(s) □□ Other points/concerns raised (specify): _____

Additional telephone contact: Yes □□ No □□ NR □□

Reason: _____

Between: _____

Additional Email contact: Yes □□ No □□ NR □□

Reason: _____ Between:

_____

Additional letter contact: Yes □□ No □□ NR □□

Reason: _____ Between:

_____

Other (details): _____ Between:

_____

Duration of joint transition planning (up to transfer of care): Number of weeks: _____

Handover of care

- Successive appointments with CAMHS then AMHS: yes □□ no □□
- Joint appointment(s) with CAMHS/AMHS: offered by CAMHS but not taken up by AMHS □□

offered but not arranged □□ offered and arranged □□

- If not offered, any reason documented? _____
- If arranged:

o attended by (list):

□□ Young person and other family or friends: _____

_____

□□ Professionals from AMHS _____

_____

□□ Professionals from CAMHS _____

_____

o Took place at: CAMHS □□ AMHS □□ other □□ (specify: _____)

o Took place at: last CAMHS appointment □□ first AMHS appointment □□ neither □□

Any other steps taken to prepare the family for the process of transition?

Young person: _____

_____

parent(s)/carer(s): _____

Period of parallel care between CAMHS and AMHS?

Duration (weeks): _____ Number of sessions: _____

Reason: _____

Documentation transferred to AMHS (tick as many as necessary)

Referral letter □ summary of CAMHS contact □ some CAMHS notes □ all CAMHS notes □

contemporary risk assessment □ Care Programme Approach documents (if on CPA) □

Other □ (specify _____)

SECTION 7: AMHS CONTACT DETAILS

CLINICAL DETAILS

First seen by: (specify number of each profession in brackets)**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( ) Family/Systemic Therapist ( )
Psychotherapist (e.g. Psychodynamic) ( )
Experiential Therapist (e.g. Art, Drama. Specify: _____) ( ) Occupational Therapist ( )
other (specify_____) ( ) **Subsequently seen by**: (specify number of each profession in brackets)**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( ) Family/Systemic Therapist ( )
Psychotherapist (e.g. Psychodynamic) ( )
Experiential Therapist (e.g. Art, Drama. Specify: _____) ( ) Occupational Therapist ( )
other (specify_____) ( )

Discipline of case manager(s)/key-worker(s): _____

First appointment offered <u>by</u> AMHS

Number of weeks between referral by CAMHS and first appointment **offered** by AMHS: _____ Joint meeting with CAMHS: yes □ no □

Appointment withdrawn and young person discharged because of:

disengagement with CAMHS □ non-response to AMHS attempts to arrange appointment □

Attended: by young person □ young person and parent(s)/carer(s) □

parent(s)/carer(s) only □ DNA □

Diagnoses / Impression following initial assessment

Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____ DSM 4 code diagnoses: _____ code: _____

Outcome of initial assessment:

discharged □□ on-going clinical management □□ DNA: Further appointment □□

Second appointment

- Number of weeks after first _____ No second appointment □□
- Type: General follow-up □□ specific intervention □□ (specify _____)
- Attended: by young person □□ young person and parent(s)/carer(s) □□ parent(s)/carer(s) only □□ DNA □□
- If DNA, outcome: Discharged □□ further appointment □□

Interventions offered overall (tick as many as relevant, and whether refused or accepted by young person)

Inpatient admission: Number ____

For each: refused / accepted _____ duration _____ status (voluntary / under MHA [specify section]) _____

Day facility attendance: specify _____ refused □□ accepted □□ Medication: specify _____ refused □□ accepted □□ Family Therapy: Behavioural □□ Systemic □□ other □□ refused □□ accepted □□ General support or follow up refused □□ accepted □□ Individual therapy: Type if noted _____ refused □□ accepted □□ Carer support: refused □□ accepted □□

Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for young person) _____ Experiential Therapy: Type: _____ refused □□ accepted □□ Consultation with other agencies: specify _____ refused □□ accepted □□

Referral

To other AMHS: specify _____ refused □□ accepted □□To other voluntary or statutory agencies: specify _____ refused □□ accepted □□ Other: specify: _____ refused □□ accepted □□

Status (at any time in contact with AMHS):

- A Looked After Child (in Care) / attending Leaving Care services

  Yes □□ No □□ NR □□
- Has a Statement of Special Educational Needs: Yes □□ No □□ NR □□
- On the Child Protection Register: Yes □□ No □□ NR □□

o If yes, specify categories:

physical abuse □□ emotional abuse □□ sexual abuse □□ neglect □□

- In a hospital for mental health problems: Yes □□ No □□ NR □□

□□ mental health unit

□□ paediatric unit

- Detained under a section of the Mental Health Act 1983

o Yes □□ No □□ NR □□

o If yes; Section 2 □□ Section 3 □□ other □□ (specify_____)

- Care Programme Approach (CPA)

o Yes □□ No □□ NR □□

o Standard □□ Enhanced □□

- Involved with YOT Yes □□ No □□ NR □□
- Refugee or asylum seeker Yes □□ No □□ NR □□

Attendance at AMHS

Discharged □□ open but lost to follow up □□ open but infrequent attendance □□

open and regular attendance □□

If discharged at any point by AMHS

o reason: presenting problem resolved altogether □□

presenting problem resolved somewhat □□ does not meet referral criteria □□

no relevant service available (specify what service: _____) □□

no relevant expertise (specify in what: _____) □□ No reason □□ DNA □□

other reason □□ (specify_____)

o Alternative sources of help suggested: no □□ yes □□ (specify _____)

o Discharge communicated: to CAMHS referrer □□ to General Practitioner □□

to young person □□ to parent(s)/carer(s) □□

If discharged and CAMHS informed, what was CAMHS response? (tick as many as relevant)

□□ continued efforts to refer to AMHS:

□□ re-referral to another AMHS

□□ telephone consultation with AMHS (n=)

□□ face to face consultation with AMHS (n=)

□□ discharged to primary care / other health service (specify:)

□□ further appointment considering options then discharged to primary care

□□ referral to other agencies (voluntary and statutory): list _____

□□ On-going input from CAMHS

If ongoing input: Number of sessions ____ Duration of contact (weeks) _____ Subsequently closed? Yes □□ No □□

In any case:

How many appointments offered in the first three months? _____ How many appointments attended (%)? _____

How long has there been between the first appointment and now / discharge in weeks? _____

If poor attendance (two successive appointments missed at any time), what efforts were made to engage the young person?

o Letters: Yes (n=) □□ No □□ NR □□

o Phonecalls: Yes (n=) □□ No □□ NR □□

o Other: specify _____

If poor attendance, what efforts were made to contact the parent(s)/carer(s)?

o Letters: Yes (n=) □□ No □□ NR □□

o Phonecalls: Yes (n=) □□ No □□ NR □□

o Other: specify _____ If poor attendance, any contact with: □□ CAMHS? Specify _____

□ General Practitioner? Specify _____

SECTION 8: DETAILS USEFUL FOR PARTICIPATION IN STAGE 4

Last known address: _____

_____

_____

Phone number: _____

Last known GP and contact details: _____

_____

_____

_____

Details of any current case manager/key worker:

Name: _____ Role: _____Service contact details:

_____

_____

_____

Any general comments on the nature of the transition (positive / negative etc)**:**

_____

_____

_____

Ethnicity Classification (from Census 2001 Ethnicity Classification System)

1. White British	7. Other Mixed Background	13. African
2. White Irish	8. Indian	14. Other Black Background
3. Other White Background	9. Pakistani	15. Chinese
4. Mixed White and Black Caribbean	10. Bangladeshi	16. Other ethnic group (please state)
5. Mixed White and Black African	11. Other Asian Background	
6. Mixed White and Asian	12. Caribbean	

Appendix 10. Participant information sheets and consent forms

UNIVERSITY OF WARWICK PARTICIPANT INFORMATION SHEET FOR SERVICE USERS

Principal Investigator: Professor Swaran Singh

Project Title: Transition of care in young offenders with ongoing mental health problems across England

Participation Duration: 1 hour 20 minutes

Research Invitation

We would like to invite you to take part in a research study that looks at transition experiences of young people like you across forensic mental health services. Before you decide if you would like to participate, it is important to understand why the study is being done, what the study is about and what it will mean if you take part. The researcher will go through this information sheet with you, to help you decide if you would like to take part and answer any questions you may have. This should take about 20 minutes.

- ***The first part of the Participant Information Sheet tells you why the study is done and what will happen to you if you take part.***
- ***Then we give you more detailed information about the study.***
- ***Do ask if you do not understand something.***

Why is this study being done?

We would like to understand how transition is planned as you move from forensic child to adult mental health services and to improve service delivery for future patients. It is important to find out how you feel about your recent transition experience to adult services and how prepared you felt for this transition.

What will happen if I take part?

We would like to talk to young people like you who have moved across services within forensic mental health services. We hope to have 20 young people in this study. If you choose to participate, we will ask you some questions about your transition experience. The interview will take up to 1 hour and if you choose to participate you just have to attend the appointment and talk to the researcher. Our conversation will be recorded so that I don't have to write while we are talking.

The researcher will visit the facility you are staying or the outpatient mental health site you are attending. You will be asked to complete a questionnaire that looks at your experiences after leaving from a medium secure unit. This will not take more than 20 minutes. We would also like to ask you whether you feel comfortable with us interviewing your parent/carer about their personal views on your transition.

Expenses?

In case you decide to take part in the study and you have to travel to the outpatient facility you and your carer (if you need someone with you) will be repaid for your travel costs.

Will taking part help me?

The research will not help you right now. But it will help us to know more about young people who experience transition and support them in the future.

What are the risks of taking part?

You might feel uncomfortable during the study talking about negative experiences you might have had with mental health services. In addition, you might feel unwell in case the interview reminds you sad events. You can stop the interview and take as much time as you need and continue a different day or you can always withdraw. You do not have to talk about anything that makes you feel unwell or upset.

Do I have to take part in the study?

You don't have to take part in this study if you don't want to. It is entirely up to you if you want to participate. You don't have to talk about anything you don't feel comfortable with. You can take time to decide if you would like to take part or not and you can contact (staff name) if you have any questions about the study and your participation.

- If you decide to take part, you will be asked to sign a consent form.

- The researcher will give you a copy of the information sheet and the consent form to keep for your records.

What will happen if I don't want to take part in the research anymore?

Just tell the researcher that you don't want to take part anymore. You don't have to give any reason. It is your choice! Your participation in the study is up to you and you can stop the interview at any time you like. Your care will be completely the same as if you refused to let us study you.

What will happen to the information already collected?

The information collected until the time you decided not to take part anymore will be kept as you agreed with your informed consent.

Any concerns?

The research is looking at your positive and negative experiences. You can tell the researcher any problems you have or had in the past. No one will know that these are your answers.

Will my information be kept private? Will anyone else know that I'm taking part?

All your information will be kept private. We will only tell your parents and your health-care provider. The only situation where this will not happen is if you tell me something that makes me concerned that there is a risk of serious harm to yourself or to another person. Nobody outside the research team will hear the recorded tapes and we will store them in a safe place.

What if during the study I feel unwell?

If during the study you feel unwell, then you can stop the interview process. Your personal information will be kept private and used in the research as agreed before with your given informed consent.

Did anyone else check the study is OK to do?

Several people have checked this study, to make sure it is alright. The University of Warwick has reviewed this study with a group of people called a Research Ethics Committee (REC), which is there to protect your rights and emotional wellbeing.

Who is organizing this study?

This study is part of the researcher's educational project taking place at the University of Warwick and the National Institute for Health Research.

What will happen when the research study stops?

The research will be talked about and written down but no one will know that you took part. We will destroy the tapes soon after the information is written down.

How can I be involved in this study?

We will give you a summary of the study's results, which you will have the opportunity to present to your peers at any facility you are staying or attending at the moment.

What to expect during the consent process?

The researcher will give you the consent form if you decide to participate in the study and will show you how to complete it. You will need to sign and date it. The researcher will also answer any questions you may have before signing the consent form. The consent process should not take more than 15 minutes.

What if there is a problem or something goes wrong?

Tell the researcher if something is wrong during the interview or after and we will take care of it and if it is necessary your clinician will be contacted.

How can I find more about the study?

Your carer or grownup you trust may be able to answer your questions. The (doctors and nurses) looking after you can also help you find out more about the study.

How can I find out more about research?

The Clinical Research Facility at this hospital has an Information section for research participants on its website or you could contact the hospital Clinical Research Facility (depending on which Trust participants reside or attend).

Thank you for taking time to read this-please ask any questions if you need to!

UNIVERSITY OF WARWICK PARTICIPANT INFORMATION SHEET FOR HEALTH-CARE PROFESSIONALS

Principal Investigator: Professor Swaran Singh

Project Title: Transition of care in young offenders with ongoing mental health problems across England

Participation Duration: 1 hour

Date:

Contact:	**Contact Type:**	**Email:**
Maria Livanou	Researcher	M.I.Livanou@warwick.ac.uk
Prof Swaran Singh	Chief Investigator	S.P.Singh@warwick.ac.uk
Dr Vivek Furtado	Academic Supervisor	V.Furtado@warwick.ac.uk

Research Purpose

We would like to invite you to take part in a research study that reflects on the transition experiences of young offenders who have been transferred from forensic child and adolescent mental health services to adult services. This study aims to understand health-care professionals' perspectives on how transition is planned as your patients moved from forensic child to adult services and to improve service delivery across forensic mental health services. Before you decide whether or not you would like to join in, we would like you to understand why the research is being done and what it would involve for you.

- **The first part of the Participant Information Sheet explains the purpose of the study and what will happen to you if you take part.**

- **Then we give you more detailed information about the conduct of the study.**
- **Do ask if anything is unclear.**

Why is this research being done?

This research study aims to address and compare the transition policy and practice followed by 7 medium secure adolescent units across England. The researchers would like to know whether there is a clear cut-off age boundary for transition from forensic child to adult mental health services and how transition is planned, prepared and executed in each Trust. This study will look at similarities and/or differences among Trusts.

What would taking part involve?

We would like to talk to you and ask you a series of questions about your and your patient's transition experiences as the young individual has recently moved from forensic child to adult mental health services. This will help us to develop ideas on how to improve services, especially for young people who may have to move from one service to another in the future. The researcher will visit your site where the interview will take place. We expect to have 20 health-care professionals involved in this study. The interview will last 1 hour. If you decide to participate you will be asked to sign a consent form. Our conversation will be recorded so that I don't have to write while we are talking.

What are the possible benefits of taking part?

We cannot guarantee any immediate direct benefits from the study to you as a participant. However, this is an opportunity for you to share your views and experiences as a health-care professional about young offenders moving from forensic child mental health services to adult mental health services and this might have indirect benefits to yourself. This is your chance to be heard and express your concerns and policy recommendations about transition processes and outcomes. In addition, your participation will help to improve service provision and delivery and even influence current policy and practice that will benefit young individuals like your patients in the future.

What are the possible disadvantages and risks of taking part?

You might feel uncomfortable talking about negative experiences you might have had with patients and/or their families and other health-care staff during the transition process. You can interrupt the interview in such case and take as much time as you need or maybe carry on a different day or you can always withdraw without any consequences affecting your professional and legal status. You do not have to disclose any information that makes you feel unwell or you do not feel comfortable to share with the researcher**.**

Any concerns?
The research is looking both positive and negative comments in order to be useful. Do not hesitate to refer to any problems you have or had in the past. The data will be anonymised when the results are reported so participants cannot be identified. All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.

How will my information be kept confidential?
All that you tell me will remain confidential. Our conversation will be recorded so I don't have to write while we are talking. Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet. The tapes will be destroyed soon after transcription.

Who has reviewed this study?
The University of Warwick has reviewed this study along with an independent group of people called a Research Ethics Committee (REC), which is there to protect your and your patients' rights, emotional wellbeing and dignity. The West-Midlands South Birmingham Research Ethics Committee has checked this study.

Who is organizing and funding this study?
This study is part of the researcher's PhD project in collaboration with the University of Warwick and NIHR CLAHRC West Midlands that is funding this study.

What will happen to the results of this study?
The results of the study will be analysed and interpreted by the research team and then will be published in scientific journals and presented at academic and medical conferences. The results will be used for the completion of the researcher's PhD project. The data will be kept anonymised throughout dissemination and the entire process.

What to expect during the consent process?
The researcher will administer the consent form if you decide to participate in the study and will provide guidance on how to complete it. The researcher will also address and answer any questions you may have before signing the consent form. The consent process should not take more than 10 minutes.

How can I find out more about research?
The Clinical Research Facility at this hospital has an Information section for research participants on its website or you could contact the hospital Clinical Research Facility (depending on which Trust participants reside or attend).

Alternatively, you can visit the following website:
http://www.nihr.ac.uk/contact/ or write to:
National Institute for Health Research
Room 132
Richmond House
79 Whitehall
London
SW1A 2NS

You can also contact the researcher if you have main concerns about the study at the following email address: M.I.Livanou@warwick.ac.uk

Thank you for taking time to read this-please ask any questions if you need to!

UNIVERSITY OF WARWICK PARTICIPANT INFORMATION SHEET FOR PARENTS

Principal Investigator: Professor Swaran Singh

Project Title: Transition of care in young offenders with ongoing mental health problems across England

Participation Duration: 1 hour

Date:

Contact:	Contact Type:	Email:
Maria Livanou	Researcher	M.I.Livanou@warwick.ac.uk
Prof Swaran Singh	Chief Investigator	S.P.Singh@warwick.ac.uk
Dr Vivek Furtado	Academic Supervisor	V.Furtado@warwick.ac.uk

Research Purpose

We would like to invite you to take part in a research study that looks at transition experiences of young people within forensic mental health services. This study tries to understand parents'/carers' perspectives on how transition is planned as your child moved from forensic child to adult mental health services and to improve service delivery across forensic mental health services. Before you agree to participate, we would like you to understand why the research is being done and what it will mean if you take part. The researcher will go through this information sheet with you, to help you decide whether or not you would like to take part and will answer any questions you may have. This should take about 20 minutes.

- **The first part of the Participant Information Sheet tells you the purpose of the study and what will happen to you if you take part.**
- **Then we give you more detailed information about the study.**
- **Do ask if anything is unclear.**

What will I have to do?

We would like to talk to you and ask you some questions about your and your child's experiences of transition as your child has moved from forensic child to adult mental health services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers. Your child has been asked to give permission to interview you. The researcher will visit either the site your child is staying or attending or you will meet at a public space (e.g. library) where the interview will take place. The interview will last 1 hour. We hope to have 10 parents/carers like you in this study. Our conversation will be recorded so that I don't have to write while we are talking.

Do I have to take part in the study?

You don't have to take part in this study if you don't want to. Participation is voluntary. There are no legal or other consequences if you don't wish to participate or if you feel that you want to withdraw anytime during the interview or if you feel emotionally upset. You don't have to share anything you that makes you feel uncomfortable. You can take time to decide if you would like to take part or not and you can contact (staff name) if you have any questions regarding the study and your participation. If you would like to take part you can make an appointment with the health services to talk to the researcher.

- If you decide to take part, you will be asked to sign a consent form.

- You will be given a copy of the information sheet and the consent form to keep for your records.

What will happen if I don't want to participate anymore?

Your participation in the study is voluntary and you can withdraw at any time you like without any legal or other consequences. The data collected until the time you decided not to take part anymore will be kept and used in this study as you agreed with your informed consent.

Expenses?

In case you decide to take part in the study and you have to travel to the outpatient facility or to another place you will be repaid for your travel costs.

How taking part will help my child and me?
The study will not help you right now. But it will help us to provide better services for future patients like your child. This is an opportunity for you to share your views and experiences about the transition process from forensic child mental health services to adult mental health services. You can express your concerns and feelings about transition planning and preparation.

What are the risks of taking part?
You might feel uncomfortable during the study talking about negative experiences you and your child have come across during the transition process. In addition, you might feel uncomfortable in case the interview reminds you of sad events related to your child's offence and/or their mental health condition. You can interrupt the interview in such case and take as much time as you need or maybe carry on a different day or you can always withdraw. You do not have to provide any information that makes you feel unwell.

Any concerns?
The research is looking both positive and negative comments in order to be useful. Feel free to refer to any problems you or your child have or had in the past. The information will be kept private when the results are reported so participants cannot be identified. All the information collected from today will be stored in a safe place with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you.

How will my information be kept private?
All that you tell me will remain private. No one outside the research team will hear the recorded tapes, and back at the University the tapes will be kept in a locked filing cabinet.

What if during the study I feel unwell?
If during the study you experience any negative feelings and distress and you feel unwell, then you can stop the interview process. Your collected personal information will be kept, remained private and used in the research as agreed before with your given informed consent.

Who has checked the study is OK to do?
The University of Warwick has reviewed this study along with an independent group of people called a Research Ethics Committee (REC), which is there to protect your rights, emotional wellbeing and dignity.

Who is organizing and funding this study?
This study is part of the researcher's educational project taking place at the University of Warwick and National Institute for Health Research.

What will happen to the results of this study?
The research will be talked about and written down but no one will know that you took part. We will destroy the tapes soon after the information is written down.

What to expect during the consent process?

The researcher will administer the consent form if you decide to participate in the study and will provide guidance on how to complete it. The researcher will also address and answer any questions you may have before signing the consent form. The consent process should not take more than 15 minutes.

How can I find out more about research?

The Clinical Research Facility at this hospital has an Information for families section on its website or you could contact the hospital Clinical Research Facility (depending on which Trust participants reside or attend).

Alternatively, you can visit the following website:
http://www.nihr.ac.uk/contact/ or write to:
National Institute for Health Research
Room 132
Richmond House
79 Whitehall
London
SW1A 2NS

You can also contact the researcher if you have main concerns about the study at the following email address: M.I.Livanou@warwick.ac.uk

Thank you for taking time to read this-please ask any questions if you need to!

Centre Number:

Study Number:

Patient Identification Number:

UNIVERSITY OF WARWICK CONSENT FORM FOR SERVICE USERS

Title of Project: Transition of care in young offenders with ongoing mental health problems across England

Name of Researchers: Prof Swaran Singh, Dr Vivek Furtado, Maria Livanou

Please check the appropriate box:

1. I have read and understood the participant information sheet for the above study. I had the opportunity to ask questions, receive enough information and discuss the study.

2. I understand that I don't have to answer all the questions and that I can decide not to continue at any time without giving any reason.

3. I give permission to the research team to have access to my medical/personal records.

4. I understand that any information recorded during the interview will be kept private and no information that identifies me will become public.

5. I understand that data collected in the study may be looked at by authorised individuals from the University of Warwick, the research group and regulatory authorities where it is relevant to my taking part in this study, I give my permission for these individuals to have access to these records and to collect, analyse and publish information from my participation in this study. I understand that my personal details will be kept private.

6. I consent to being audio recorded as part of the project.
7. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Centre Number:

Study Number:

UNIVERSITY OF WARWICK CONSENT FORM FOR HEALTH-CARE PROFESSIONALS

Title of Project: Transition of care in young offenders with ongoing mental health problems across England

Name of Researchers: Prof Swaran Singh, Dr Vivek Furtado, Maria Livanou

Please initial all boxes

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.

4. I understand that this research will look at differences and/or comparisons among Trusts.

5. I understand that data collected in the study may be looked at by authorised individuals from the University of Warwick, the research group and regulatory authorities where it is relevant to my taking part in this study, I give my permission for these individuals to have access to these records and to collect, analyse and publish information from my participation in this study. I understand that my personal details will be kept confidential.

6. I consent to being audio recorded as part of the project.

7. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Centre Number:

Study Number:

UNIVERSITY OF WARWICK CONSENT FORM FOR PARENT/CARER

Title of Project: Transition of care in young offenders with ongoing mental health problems across England

Name of Researchers: Prof Swaran Singh, Dr Vivek Furtado, Maria Livanou

Please check the appropriate box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that any information recorded in the investigation will remain confidential and no information that identifies me will be made publicly available.

4. I understand that data collected in the study may be looked at by authorised individuals from the University of Warwick, the research group and regulatory authorities where it is relevant to my taking part in this study, I give my permission for these individuals to have access to these records and to collect, analyse and publish information from my participation in this study. I understand that my personal details will be kept confidential.

5. I consent to being audio recorded as part of the project.

6. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Appendix 11. Interview schedules

Topic List: Interview Schedules for Service Users

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I am a PhD student-researcher based at _____. We are doing a study looking at what happens when a person who is attending a forensic child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As you have moved from one service to another we would like to talk to you today about your experiences of mental health services and the time when you stopped attending forensic Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

Schedule for service users

- I would like to remind you that all that you tell me will remain confidential. The only situation where this would not apply is if you told me something that made me concerned that there was a risk of serious harm to either yourself or to another person.
- All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.

- ***Consent form.***

1. Child and Adolescent services – entry, illness course and overall experience

Could you tell me the story about how you first came to forensic Child and Adolescent Mental Health Services?
(Prompts: Who asked you to be seen there and why?
How old were you?)

Could you tell me about your experiences of using Child and Adolescent Mental Health Services?
(Prompts: What happened at CAMHS?
Was there anything helpful?
Was there anything unhelpful?
Is there anything you would change?)

2. Transition Planning

How did you realise that you would have to move from forensic Child and Adolescent Mental Health Services to the Adult service?

Was there anything that helped or was unhelpful in preparing you for this move?

Thinking back, is there anything that would have been more helpful in preparing you for the move, or anything that you would change?

3. Transition issues

What do you think were the main reasons why you were referred to adult services?

Was the reason something that makes sense to you?

Thinking about you and your family, what would be good reasons for you to move from the Child and Adolescent Mental Health Services to the Adult services?

4. Adult services – entry, engagement and defaulting, and overall experience

Have you been to the adult service you were referred to?

(Prompts: If so 'in what ways?'
If no, 'why not?')

What has it been like going there?

5. Comparison of Adult to Child and Adolescent services

Are there any ways in which it has been better/easier/more helpful going to the adult service than CAMHS?

Are there any ways in which CAMHS was better/easier/more helpful than going to than the Adult service?

6. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on you?

(Prompts:
Independence from parent

Engagement with services

Understanding of problems

Effects on severity of mental health problems-Better?, Worse?,

Any new problems?

What are you doing now? (college/working/hobbies, etc)

Is there anything else you would like to say about the transition from forensic CAMHS to adult services that we haven't talked about yet?

Topic List: Interview Schedule for forensic CAMHS Key-workers

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I am a PhD student/researcher based at _____. We are doing a study looking at what happens when a person, who is attending a forensic child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As your client has moved from one service to another we would like to talk to you today about your and your client's experiences of mental health services and the time when your client stopped attending forensic Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

- I would like to remind you that all the information obtained in this study will be entirely confidential. It will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the university the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who was interviewed are combined anonymously when the results are reported so no one can be identified.

- **Consent form**

1. Transition Planning

Could you tell me what your service did once it was decided [name of service user] needed to transfer to another service?

(Prompts:

- *How did you go about making the referral?*
- *Which service were they transferred to? Why?*
- *What is your ideal of a good transfer of care? Which aspects did X receive/not receive?*
- *Any difficulties in accessing this service?*
- *What did CAMHS do to help client with transition?*

2. Transition issues

What were the main reasons why X was referred to you?

(Prompt: Appropriateness?)

3. Comparison of Adult to Child and Adolescent services

To your knowledge are there any differences in the service [name of service user] receives in adult services when compared with CAMHS?

(Prompts in terms of:

- Accessibility (out of hours/emergency contact)
- Continuity of care (seeing the same individuals, keyworker contact, being able to form a therapeutic relationship with the client)
- Quality of care (the benefits of any interventions offered, the quality of information and care given)
- Their diagnosis
- The types of staff they see
- Types of intervention)

What services do you expect X to receive in adult service?

4. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on [name of service users]*?*

(Prompts:
Independence from parents, engagement with services, understanding of problems and effects on severity of mental health problems-Better?, Worse?, Any new problems?)

Is there anything else you would like to mention that we haven't talked about yet?

Topic List: Interview Schedules for AMHS Care-coordinator

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I am a PhD student-researcher based at _____. We are doing a study looking at what happens when a person who is attending a forensic child and adolescent mental health clinic has their care transferred to an adult mental health service.

As your client has moved from one service to another we would like to talk to you today about yours and your client's experiences of mental health services and the time when your client stopped attending forensic Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

- I would like to remind you that all the information obtained in this study will be entirely confidential. It will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.

1. Transition Planning

Could you tell me what happened once it was decided [name of service-user] would come to your service?

(Prompts:

- *Any discussion between you and your client's key-worker/staff at CAMHS?*

- *Was anything else done (e.g. Discussion with client? giving written information to the client?, or arranging a visit/a period of joint-working?*
- *Could anything else have been done?).*

2. Transition issues

What were the main reasons why X was referred to you?

(Prompt: Appropriateness?)

3. Comparison of Adult to Child and Adolescent services

To your knowledge are there any differences in the service [name of service user] receives in Adult services when compared with CAMHS?

(Prompts in terms of:
- *Accessibility (out of hours/emergency contact)*
- *Continuity of care (seeing the same individuals, key-worker contact, being able to form a therapeutic relationship with the client)*
- *Quality of care (the benefits of any interventions offered, the quality of information and care given)*
- *Their diagnosis*
- *The types of staff they see*
- *Types of interventions)*

4. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on [name of service user]*?*

(Prompts:
Independence from parents,
engagement with services,
understanding of problems
effects on severity of mental health problems-Better?, Worse?
Any new problems?)

Is there anything else you would like to mention that we haven't talked about yet?

Topic List: Interview Schedules for Carers

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I'm a PhD student-researcher based at _____. We are doing a study looking at what happens when a person who is attending a forensic child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As your child has moved from one service to another we would like to talk to you today about your and [name of service user] experiences of mental health services and the time when he stopped attending forensic Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

Schedule for carer

- I would like to remind you that everything that you tell me will remain anonymous. All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.
- ***Consent form***

1. Child and Adolescent Mental Health services – entry, illness course and overall experience

Could you tell me the story about how X first came to forensic Child and Adolescent Mental Health Services?
(Prompts: What was the problem?
Who asked him/her to be seen there and why?
How old was s/he?)

Could you tell me about your and X's experiences of using Child and Adolescent Mental Health Services?
(Prompts: What happened at CAMHS?
Can you think of anything particularly helpful?
Anything you found unhelpful?
Is there anything you would change?)

2. Transition Planning

How did you realise that X would have to move from the Child and Adolescent Mental Health Services to the Adult service?

Was there anything that helped or was unhelpful in preparing X and you for this move?

Thinking back, is there anything that would have been more helpful in preparing you and X for the move?

3. Transition issues

What do you think were the main reasons why X was referred to adult services?

Was the reason something that makes sense to you?

Thinking about X and your family, what would be good reasons for X moving from the Child and Adolescent Mental Health Services to the Adult services?

4. Adult services – entry, engagement and defaulting, and overall experience

Have you or X been to the adult service X was referred to?

Prompts: If so 'in what ways?',
If no, 'why not?'

What has it been like going there?

5. Comparison of Adult to Child and Adolescent services

What have you found to be the main differences in adult services as compared to the child and adolescent services?

Are there any ways in which it has been better/easier/more helpful going to the adult service than CAMHS?

Are there any ways in which CAMHS was better/easier/more helpful than going to than the Adult service?

6. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on you or X?

Prompts:

Independence from parent

Engagement with services

Understanding of problems

Effects on severity of mental health problems-Better?, Worse?,

Any new problems?

Is there anything else you would like to say about the transition from forensic CAMHS to adult services that we haven't talked about yet?

Appendix 12. Publications

Mentally disordered young offenders in transition from child and adolescent to adult mental health services across England and Wales

Maria I. Livanou, Vivek Furtado and Swaran P. Singh

Abstract

Purpose – *This paper provides an overview of transitions across forensic child and adolescent mental health services in England and Wales. The purpose of this paper is to delineate the national secure services system for young people in contact with the youth justice system.*

Design/methodology/approach – *This paper reviews findings from the existing literature of transitions across forensic child and adolescent mental health services, drawing attention to present facilitators and barriers to optimal transition. The authors examine the infrastructure of current services and highlight gaps between child and adult service continuity and evaluate the impact of poor transitions on young offenders' mental health and wellbeing.*

Findings – *Young offenders experience a broad range of difficulties, from the multiple interfaces with the legal system, untreated mental health problems, and poor transition to adult services. Barriers such as long waiting lists, lack of coordination between services and lack of transition preparation impede significantly smooth transitions.*

Research limitations/implications – *The authors need to develop, test and evaluate models of transitional care that improve mental health and wellbeing of this group.*

Practical implications – *Mapping young offenders' care pathway will help to understand their needs and also to impact current policy and practice. Key workers in forensic services should facilitate the transition process by developing sustainable relationships with the young person and creating a safe clinical environment.*

Originality/value – *Transition of care from forensic child and adolescent mental health services is a neglected area. This paper attempts to highlight the nature and magnitude of the problems at the transition interface in a forensic context.*

Keywords *Mental health services, Transition, Mental health problems, Forensic services, Young offenders, Care pathway*

Paper type *General review*

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Background

Young offenders comprise a large proportion of the prison population and are at high risk of experiencing mental health disorders (Prison Reform Trust, 2012). In 2009, offenders under 21 made up 14 per cent of the overall prison population in England and Wales (Bradley KJCB, 2009). The Bradley Commission reported that 1,323 children aged between 10 and 18 years were detained, excluding those in secure hospitals (Snodgrass and Preston, 2015). Up to 81 per cent of young people within criminal justice agencies are known to present with mental health problems (Hagell, 2002), while a UK study identified 95 per cent of young offenders aged 16 to 20 years as having a mental health disorder (Lader *et al.*, 2003).

mood and severe self-harm (Hill *et al.*, 2014) that might imply an emerging personality disorder. It is hypothesised that these symptoms could be a result of significant abuse and trauma during periods of development and maturation (Dimond and Chiweda, 2011).

Young people with learning difficulties can be referred to specialist mental health units that focus on their particular disability needs. Legally, young offenders with learning disabilities cannot be detained under the Mental Health Act unless they present with violent behaviour, as merely a diagnosis of mental impairment does not suffice for detention in hospital (Dimond and Chiweda, 2011).

ADHD is also commonly diagnosed among young people within the criminal justice system. The TRACK project, the largest study on transitions across mental health services in the UK, identified that 23.5 per cent of young individuals with ADHD and autism spectrum disorders were not accepted by adult services at the point of transition (Khan and Wilson, 2010). A possible explanation is that healthcare providers lack the training to treat individuals with ADHD (Hall *et al.*, 2013; Swift *et al.*, 2013). Therefore, services should tailor the transition process according to the needs of special populations, such as young people with ADHD. Designing specific care pathways for ADHD groups should be a priority for adult services.

Transitions from forensic child and adolescent to AMHS

Transitional age boundaries

Transitional age boundaries are problematic in the UK as it is unclear at what age adult services start being accountable for young people (Singh, Paul, Ford, Kramer, Weaver, McLaren, Hovish, Islam, Belling and White, 2010). Child mental health services provide care for young people until they reach the age of 18. Age is the only criterion for transferring young people to adult care disregarding factors such as self-independence and readiness for transition (Singh, Paul, Islam, Weaver, Kramer, McLaren, Belling, Ford, White and Hovish, 2010). However, the Joint Commissioning Panel for Mental Health (2012), recommended that commissioners should tailor transfers according to the needs of the most vulnerable groups including children with learning difficulties and young offenders. It follows that using age, as the only criterion for transitioning young people to adult services should be reconsidered. The only argument for adhering to age cut-off criteria is that age boundaries aid organisational and structural purposes within services (Inspection CJJ, 2012).

Adult services are structured differently to child services with the latter providing more routine-based milieus (Singh, Paul, Islam, Weaver, Kramer, McLaren, Belling, Ford, White and Hovish, 2010). Barrow Cadbury Commission (2005) suggested using a life course approach integrating both adolescents and young adults, as it is unlikely that their needs significantly change once they turn 18. Although these recommendations refer to young adults in the criminal justice system, they can be extended to young people moving from forensic child to adult services considering that reaching a chronological age of 18 does not ensure entering to adulthood at a developmental level.

Davis (2003) explains that developmental transitions occur in the 16-25 age group and many of these young people are not ready for adulthood due to the complexity of their emotional needs. For example, young people diagnosed with learning disabilities and autistic spectrum disorders (Swift *et al.*, 2013) are not developmentally ready for such a transition. However, we currently lack empirical research on transitions of young people with learning disabilities in contact with forensic services.

Factors influencing the transition process

A recent systematic review on transition models, which included studies from the USA and Europe, highlighted that the most substantial difficulty in the transition process is inefficient communication between CAMHS and AMHS (Paul *et al.*, 2014).

Transitional delays

The Managing Transitions from Secure Settings project followed-up six young people from secure settings in the UK (Hart, 2009). The findings showed that factors, such as housing and

education, should be ensured for the young persons' return to their communities. Transition looked the most discouraging factor since young individuals were notified about their placement even a day before their transition (Hart, 2009). Delays in transition within the youth justice system and lack of proper planning in regards to new placements concurred with lack of coordination among services. The report illustrates that transitions within and across the justice system are rarely planned and usually occur in short notice lacking young person's proper transition management (Hart, 2009). Knowing the transition destination might be a protective factor for young people (Swift *et al.*, 2013) to avoid feelings of distress and insecurity. The findings highlight that young people need to have an active role in shaping their transitions, as they can acknowledge their own needs more efficiently. Therefore, it is essential that they be informed timely about their transition placement (Kane, 2008; Swift *et al.*, 2013).

One of the common reasons that accounts for transition delays is lack of bed availability in secure hospitals. As a result, long waiting lists turn transition into a confusing and frustrating experience for young people. Bed shortage along with services infrastructural weaknesses can severely interrupt the transition process. When an initial placement has been identified and responding services cannot provide a bed at the time of referral, new referrals and discharge plans have to take place resulting in additional transition delays (Kane, 2008). Meanwhile, young people's mental health might exacerbate and new problems arise, such as risk; the young person might become more aggressive and the level of security they were referred to might not be appropriate anymore. An effective and structured post-discharge plan necessitates prior knowledge about the post-transition placement and failing to provide such information impedes young persons' commitment to future plans.

Family involvement and sustained relationships

The role of the family throughout the transition process has been discussed multiple times in the current literature (Swift *et al.*, 2013). Families should be an integral part of transitions and their involvement is significantly important. Most young persons are attached to their families and the young persons' recovery sometimes partially relies on the family's role (Kane, 2008). As Swift *et al.* (2013) highlight, parental involvement might be necessary at the early stages of transition to AMHS. However, the case might be different for certain cohorts of young people and young offenders, in particular. Young people involved in the youth justice system often come from families lacking secure attachment and, parents refuse to be involved. Further, many young offenders are looked after children and have spent time in foster care. As Kane (2008) reports, relationships with staff and healthcare professionals in inpatient hospitals might be the only sustained relationships young people ever had.

The transition to adult services might perpetuate the pattern of inconsistent relationships in these young people's lives. Accordingly, attachment is a key element in the transition process, as previous research has addressed (Kane, 2008). Abrupt transitions where the young person loses relationships with staff and attachment to places can severely interrupt a smooth transition. Adult hospitals do not rely on attachment theory similarly to child services (Kane, 2008). Therefore, transferring to adult hospitals can potentially traumatise young people, as they have to cope with new care models. Child services should liaise with adult care and work collaboratively on managing effectively attachment, loss, and transition.

Continuity of care

The concept of continuity of care should be understood differently for young people moving to the community than those transferring to forensic adult inpatient services. Those returning to the community are diverted from the justice system and need different care than young people remaining in the forensic system. The dynamics of transition depends heavily on the new placement. Presumably, transition for young people moving in between secure hospitals is smoother. Young people placed in community settings from inpatient services need the involvement of multiple services' to ensure community integration. However, for young individuals moving to adult medium or high secure hospitals issues surrounding hope should be examined given that their detention in such services might be prolonged.